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MIDWIVES OF MISSISSIPPI

MASTER OF ARTS

HISTORY DEPARTMENT

LAUREL LANE NOEL

MAY 2011

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ABSTRACT

Across the United States as late as 1910, midwives delivered half of all babies. Their practice was primarily among women of white European descent and African American women of the South. The practice of midwifery was commonplace in Mississippi. Together, black midwives and white nurses would help to implement a new public healthcare structure in Mississippi during the 1920s. Records of the Mississippi State Board of Health together with letters from midwives and public health nurses' reports put midwives at the heart of the story of public health reform. Already held in high esteem by their own communities, midwives came to be more respected by the white community as a result of education and the embrace of new practices. Midwives gradually gained in the estimation of the medical community as well.

Underprivileged African American women throughout Mississippi and the South contributed to the well being of their communities through public health work—one of the few venues open to African American women at the time. The majority of these women became midwives because they saw a need within their community and wanted to help their neighbors. Midwives assisted and cared for birthing women at a time when many community hospitals rejected African American women as patients, either due to racism or the women's inability to pay. After the passage of the Hill-Burton Act in 1946, treating poor women, who only a few years prior could not afford the luxury of a doctor, became financially lucrative for physicians. Through oral interviews and archival

material, this thesis will prove that even after midwives became educated and adhered to strict state guidelines to be able to continue their practice as midwives, as a result of the Hill-Burton Act, they were robbed of their practice because they infringed on the white medical community's monetarily profitable business.

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I: HISTORIOGRAPHY AND INTRODUCTION

Witches, Midwives, and Nurses: A History of Women Healers, originally published in 1973 by Barbara Ehrenreich and Deirdre English, discusses the different ways “women were abused or treated unjustly by the medical system.”¹ As feminist and Marxist authors, English and Ehrenreich are nonacademic historians well-known for examining the published works of physicians, social scientists, and politicians. In the 1970s, English was the top editor for *Mother Jones*, a magazine with a strong voice for social justice and named for the Irish immigrant Mary Jones who traveled throughout the United States championing causes of the poor working class, such as twelve hour days, and the abolition of company housing and company stores.² Ehrenreich received a doctorate in biology from The Rockefeller University in New York City but decided not to pursue a career as a research scientist and instead became involved in politics as an activist for social change. She currently serves as vice chair of the Democratic Socialists of America.³

According to Ehrenreich and English, at a small conference on women’s health held in rural Pennsylvania in 1972, they discovered that the medical profession, at the time over 90 percent male, had replaced and expelled “a much older tradition of female

¹ Barbara Ehrenreich and Deirdre English, *Witches, Midwives & Nurses: A History of Women Healers* (New York City: The Feminist Press, Second Edition, 2010), 8.

² Elliot J. Gorn, “The History of Mother Jones.” Available from <http://motherjones.com/about/what-mother-jones/our-history>. Accessed February 10, 2011.

³ Democratic Socialists of America, Available from <http://www.dsusa.org/about/structure.html>. Accessed March 27, 2011.

lay healing, including both midwifery and a range of healing skills, while closing medical education to women.”⁴ Ehrenreich and English believe that “the ignorance and disempowerment of women that” they “confronted in the 1970s were not longstanding conditions, but were the result of a prolonged power struggle that had taken place in America in the early nineteenth century, well before the rise of scientific medicine.”⁵ In the European early modern age the authors discovered a comparable power struggle and examined how female lay healers of the same period were often under attack as “witches.” Even though women are told that they are preordained to be helpers and not independent healers, the authors found that women have been independent healers for centuries, almost always the only healers for women and the poor.⁶ They also concluded that “if anything, it was the male professionals who clung to untested doctrines and ritualistic practices—and it was the women healers who represented a more human, empirical approach to healing.”⁷

In their study, the authors are attempting to learn how women arrived at this subservient status within the medical profession from the former status of leadership. They learned that “the suppression of women health workers and the rise to dominance of male professionals was not a ‘natural’ process, resulting automatically from changes in medical science, nor was it the result of women’s failure to take on healing work. It was an active *takeover* by male professionals.”⁸ At stake was the political and financial control of medicine that would result in jurisdiction over its institutional organizations, its

⁴ Ibid., 11.

⁵ Ibid., 11.

⁶ Ibid., 27.

⁷ Ibid., 27.

⁸ Ibid., 28.

philosophy and traditions, and its status and financial gains. The authors argue that the repression of female healers by the male medical establishment was in the beginning an important political battle in the history of sex struggle. The standing of female healers has risen and fallen with the standing of women. “When women healers were attacked, they were attacked as women.”⁹

Secondly, it was a political struggle because it was a class struggle. Female healers were doctors to the people in their communities. Their medicinal practices were part of a community’s sub-culture. Until modern times, women’s healing practices have flourished in the midst of insubordinate lower-class movements, which have fought for liberation from conventional powers. “Male professionals, on the other hand, served the ruling class—both medically and politically. The universities, the philanthropic foundations, and the law have advanced their interests. They owe their victory—not so much to their own efforts—but to the intervention of the ruling class they serve.”¹⁰

In the first section of the book, Ehrenreich and English discuss witch hunting, which spanned more than four centuries in Europe. They argue that “the witch craze took different forms at different times and places, but never lost its essential character: that of a ruling class campaign of terror directed against the female peasant population.”¹¹ The witch-healer was a great threat to the Protestant and Catholic churches because she trusted in her senses rather than on religious devotion or doctrine, she had faith in “trial and error, cause and effect.”¹² Her approach was not religiously unreceptive, but it was vigorously inquisitive. She relied on her skill to discover methods for dealing with

⁹ Ibid., 29.

¹⁰ Ibid., 29.

¹¹ Ibid., 33.

pregnancy, childbirth, and disease—whether through medicinal remedies or charms. In brief, “her magic was the science of her time.”¹³

According to the authors, witch-hunts did not get rid of the lower-class female healer, but they eternally branded her as irrational and malicious. So systematically were female healers “discredited among the emerging middle classes that in the seventeenth and eighteenth centuries it was possible for male practitioners to make serious inroads into that last preserve of female healing—midwifery.”¹⁴ In England “non-professional male practitioners—‘barber-surgeons’—led the assault,” maintaining scientific dominance based on their use of the obstetrical forceps.¹⁵ “The forceps were legally classified as a surgical instrument, and women were legally barred from surgical practice.”¹⁶ Because of “barber-surgeons,” “obstetrical practice among the middle class was quickly transformed from a neighborly service into a lucrative business, in which real physicians entered in force in the eighteenth century.”¹⁷ Throughout England, female midwives organized and accused the male interlopers of “commercialism and dangerous misuse of the forceps.”¹⁸ The women’s pleas proved useless, however, and they were effortlessly dismissed as uninformed old women hanging on to outdated superstitions.¹⁹

Beginning in the early 1800s, an increasing number of university-trained physicians made an effort to differentiate themselves from the multitude of lay healers.

¹² Ibid., 48.

¹³ Ibid., 48.

¹⁴ Ibid., 57.

¹⁵ Ibid., 57.

¹⁶ Ibid., 58.

¹⁷ Ibid., 59.

¹⁸ Ibid., 59.

¹⁹ Ibid., 59.

“The most important real distinction was that the formally trained, or ‘regular’ doctors as they called themselves, were male, usually middle class, and almost always more expensive than the lay competition.”²⁰ The “regulars” practices were mainly restricted to middle-and upper-class patients who could pay for the prestige of being cared for by a university-trained physician from their own social class. By 1800, it was even common in fashionable circles for upper-and middle-class women to be treated by “regular” doctors for obstetrical care.²¹

According to the authors, the allegedly “trained” doctors were no more efficient than the lay practitioners in medical proficiency and hypothesis. Their “formal training” meant little. Medical curricular differed in length from a few months to two years, and countless medical institutions had no scientific facilities. “‘Regulars’ were taught to treat most ills by ‘heroic’ measures: massive bleeding, huge doses of laxatives, calomel (a laxative containing mercury) and, later, opium. There is no doubt that their ‘cures’ were often either fatal or more injurious than the original disease.”²² The “irregular” healers were undeniably less dangerous and more effective than the educated doctors because they preferred mild herbal treatments and dietary modifications over heroic interference. Perhaps these lay practitioners possessed no more medical knowledge than the “regulars,” but at least they were less likely to do the patient harm. Eventually the lay healers might have supplanted the “regulars,” but the leading classes did not recognize them. The “regulars,” with their intimate connection to the higher class, had governmental influence. By 1830, thirteen states had voted for medical licensing laws

²⁰ Ibid., 66.

²¹ Ibid., 66.

²² Ibid., 67.

banning lay practitioners and instituting the ‘regulars’ as the only officially authorized physicians.²³

“Because professions are the creation of a ruling class, to become the medical profession, the ‘regular’ doctors needed, above all, ruling class patronage. By a lucky coincidence for the ‘regulars,’ both the science and the patronage became available around the same time, at the turn of the century.”²⁴ French and principally German scientists confirmed the germ theory of disease in 1871, which offered a logical foundation for disease prevention and treatment. “While the run-of-the-mill American doctor was still mumbling about ‘humors’ and dosing people with calomel, a tiny medical elite was traveling to German universities to learn the new science.”²⁵ After these German-trained physicians came back to the United States, they founded a medical school at newly created Johns Hopkins University.²⁶

In the meantime the United States was developing into the global manufacturing leader of the world. Prosperity developed from oil, coal, and an ample pool of American workers. “For the first time in American history, there were sufficient concentrations of corporate wealth to allow for massive, organized philanthropy, i.e., organized ruling-class intervention in the social, cultural, and political life of the nation.”²⁷ Philanthropic organizations were set up as the enduring channel of this involvement—the Rockefeller and Carnegie foundations developed in the first decade of the twentieth century. For English and Ehrenreich, this is a clear example of Karl Marx’s philosophy in which

²³ Ibid., 68.

²⁴ Ibid., 80.

²⁵ Ibid., 80.

²⁶ Ibid., 80.

²⁷ Ibid., 81.

battles between social classes perform a principal role in comprehending a culture's purportedly unavoidable improvement from upper-class tyranny under a free enterprise economic system to a collectivist and egalitarian social order. Medical "reform" and the establishment of a reputable, scientific American medical vocation was one of the first and most important items on their agenda.²⁸

"The group of American medical practitioners that the foundations chose to put their money behind was, naturally enough, the scientific elite of the 'regular' doctors, the majority of which were themselves ruling class, and all were urbane, university-trained gentlemen."²⁹ Beginning in 1903, millions of dollars in philanthropic donations started to flow into medical schools. The requirements were clear: "conform to the Johns Hopkins model or close. To get the message across, the Carnegie corporation sent a staff man, Abraham Flexner, out on a national tour of medical schools—from Harvard right down to the last third-rate commercial school."³⁰

Flexner almost single-handedly determined which institutions would receive funds—and therefore survive. The larger, more prestigious schools received sizeable financial endowments. "As for smaller, poorer schools, which included most of the sectarian schools and special schools for blacks and women—Flexner did not consider them worth saving. Their options were to close, or to remain open and face the public denunciation in the report Flexner was preparing."³¹

According to *American Medical Education 100 Years after the Flexner Report*, at the heart of Flexner's belief was the idea that recognized methodical analysis, the sort of

²⁸ Ibid., 82.

²⁹ Ibid., 82.

³⁰ Ibid., 82.

philosophy essential to the biological sciences, must possess preference in the academic education of doctors. Flexner also conceived of an experimental period of instruction in academically concentrated hospitals, where sympathetic students would engage in study inspired by the problems that appeared during the treatment of patients and instruct their students to follow their example. For Flexner, research was imperative because it brought about more effective patient care and instruction.³²

Published in 1910, the Flexner Report was the philanthropic societies' ultimatum to the medical establishment in the United States. As a result, numerous medical schools closed, including six of America's eight black medical institutions and the greater part of "irregular" schools that had been a refuge for female students. "Medicine was established once and for all as a branch of 'higher' learning, accessible only through lengthy and expensive university training. It is certainly true that as medical knowledge grew, lengthier training did become necessary."³³ Nevertheless, Flexner and the foundation were determined that such education would not be made available to the majority of lay healers and "irregular" doctors. "Instead, doors were slammed shut to blacks, to the majority of women, and to poor, white men. In fact, in Flexner's report he bewailed the fact that any 'crude boy or jaded clerk' had been able to seek medical training. Medicine had become a white, male, middle-class occupation."³⁴

In recent years the rising turmoil of the medical management environment has produced a subsequent series of circumstances unfavorable to medical instruction as

³¹ Ibid., 83.

³² Malcolm Cox and David M. Irby, "American Medical Education 100 Years after the Flexner Report," *The New England Journal of Medicine* (2006): 2-4, accessed February 12, 2011 doi: <http://www.nejm.org/doi/full/10.1056/NEJMr055445>.

³³ Ehrenreich, 84.

³⁴ Ibid., 84.

Flexner envisioned it. Clinical educators have been under increasing coercion to produce profits by supplying care to patients who have the ability to pay. Consequently, they have less time available for teaching. Also, the profit-making tone of the marketplace has leaked into countless university medical centers. Students listen to hospital directors more concerned with “throughput,” “capture of market share,” “units of service,” and the monetary “bottom line” than about the avoidance and relief of human agony. From this ethos, students realize that health care as a business could jeopardize the medical field as a mission to help those in need.³⁵

As a result of the Flexner Report, in one state after another strict licensing laws clinched the physician’s control over the medical establishment. “All that was left was to drive out the last holdouts of the old people’s medicine—the midwives.”³⁶ The fact that fifty percent of all babies were delivered by midwives was unendurable to the recently established obstetrical field. Each midwife-attended birth was one more case lost to educational training and research. “America’s vast lower class resources of obstetrical ‘teaching material’ were being wasted on ignorant midwives—five million dollars could have been going to ‘professionals.’”³⁷

Yet, according to Barbara Ehrenreich and Deirdre English, in public the obstetricians introduced their assault on midwives on behalf of science and improvement. The medical establishment derided midwives as “hopelessly dirty, ignorant, and incompetent.”³⁸ Mainly, they were blamed for the pervasiveness of puerperal sepsis (uterine infections) and neonatal ophthalmia (blindness as a result of parental infection

³⁵ “Ibid., 2.

³⁶ Ehrenreich, 86.

³⁷ Ibid., 86.

with gonorrhea). Both conditions were easily avoidable by using methods even the least literate midwife could effortlessly understand—hand washing for puerperal sepsis, and eye drops for the ophthalmia. Consequently, the apparent answer for a truly humanitarian “obstetrical profession would have been to make the appropriate preventative techniques known and available to the mass of midwives. This is in fact what happened in England, Germany, and most other European nations: midwifery was upgraded through training to become an established, independent” profession.³⁹

The American obstetricians, according to these critics of the medical system, had no desire to enhance obstetrical treatment. Indeed, in 1912 a report by a Johns Hopkins professor revealed that the majority of university-trained physicians in the United States were less knowledgeable than the lay midwives. “Not only were the doctors themselves unreliable about preventing sepsis and ophthalmia, but they also tended to be too ready to use surgical techniques which endangered mother or child. If anyone, then, deserved a legal monopoly on obstetrical care, it was the midwives, not the doctors.”⁴⁰

Unfortunately, the doctors had the influence with the professional elites, and the midwives did not. Because of extreme coercion from the medical establishment, numerous states throughout the country passed laws banning midwifery and limiting the practice of obstetrics to physicians. “For poor and working-class women this actually meant worse—or no—obstetrical care. For instance, a study of infant mortality rates in Washington showed an increase in infant mortality in the years immediately following

³⁸ Ibid., 86.

³⁹ Ibid., 86.

⁴⁰ Ibid., 87.

the passage of the law forbidding midwifery.”⁴¹ For the modern, male medical profession the sanction on midwives helped remove some of their competition. Consequently, women were cut off from their last toehold as autonomous lay healers.⁴²

English and Ehrenreichs’ manifesto undoubtedly influenced later historians interested in the history of women. The authors’ work influenced the women’s health movement of the 1970s. According to Pat Milmo McCarrick, the 1970s saw a rise in the belief that women’s normal health status was different from that of men and as a result should be treated differently. Activist women noted and protested against the exclusion or under representation of women in medical investigation. As a result, there emerged a desire among historians to begin investigations to recognize variations in health care, to distinguish and evaluate “disease symptoms,” and to enhance “diagnosis and prognosis” for those marginalized factions who have been mostly overlooked in past decades.⁴³

Using the long-ignored diary of midwife Martha Ballard as the foundation for her research, Laurel Thatcher Ulrich reconstructs an intriguing story of female life and vocation in the pre-industrial United States in frontier Hallowell, Maine⁴⁴ *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*, reveals the external and internal spheres of life in early American families and communities from the viewpoint, previously unwritten, of a “woman whose very name disappeared from the

⁴¹ Ibid., 87.

⁴² Ibid., 87.

⁴³ Pat Milmo McCarrick, “Gender Issues In Health Care,” National Reference Center for Bioethics Literature, The Joseph and Rose Kennedy Institute of Ethics, Georgetown University, accessed February 19, 2011, doi: <http://bioethics.georgetown.edu/publications/scopenotes/sn27.pdf>.

⁴⁴ Judy Barrett Litoff, review of *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*, by Laurel Thatcher Ulrich, *The American Historical Review*, Vol. 96, No. 3 June 1991), 950-951, accessed: September 30, 2010, <http://www.jstor.org/stable/2162604>.

records and consciousness even of contemporaries."⁴⁵ Ballard's diary, which runs from 1785 to 1812, seems "so trivial, so useless, so irrelevant to historians' concerns."⁴⁶

According to reviewer Phillip Greven, however, it is exactly this feature of the record that Ulrich correctly observes, "it is in the very dailiness, the exhaustive, repetitious dailiness, that the real power of Martha Ballard's book lies.... For her, living was to be measured in doing. Nothing was trivial."⁴⁷

Ulrich begins each of the ten chapters with extended, unabridged segments from Ballard's original journal. "These passages are followed by interpretive essays in which Ulrich skillfully incorporates information from a wide variety of materials ranging from wills, tax lists, deeds, court records, and town-meeting minutes to medical treatises, novels, religious tracts, and the papers of Maine physicians."⁴⁸ By contrasting the original diary accounts with the analytical essays, the author enables modern historians to understand better the broader implication of the journal while also imparting illustrations of how "important" information is frequently "submerged in the dense dailiness of the complete excerpt."⁴⁹

The range and insightfulness of important remarks discovered in Ballard's diary astonish the reader. According to reviewer Judy Barrett Litoff, we "learn about early American courtship, marriage practices, and sexual mores as well as quilting bees,

⁴⁵ Philip Greven, *The William and Mary Quarterly*, Third Series, Vol. 48, No. 2 (Apr., 1991): 325-327, published by: Omohundro Institute of Early American History and Culture Stable, accessed September 30, 2010, doi: <http://www.jstor.org/stable/2938081>.

⁴⁶ Ibid., 325.

⁴⁷ Laurel Thatcher Ulrich, *The Life of Martha Ballard, Based on Her Diary, 1785-1812* (New York: Vintage Books, 1990), 9.

⁴⁸ Litoff, 950.

⁴⁹ Ulrich, 34.

weaving, gardening, and tending to livestock.”⁵⁰ The account reveals that Ballard’s domestic life was made of two distinct “but cooperative family economies in which her husband traded lumber with landowners and merchants while she bartered cabbages and textiles with the wives and settled midwifery accounts with the men.”⁵¹ The midwife’s journal includes insightful, although subtle, remarks regarding family members, premarital sex, incest, rape, illegitimacy, and even murder and suicide.⁵²

It is the everyday life of female existence that composes the innermost topics of Ballard’s diary and Ulrich’s book. Ulrich declares that “it is the structure of the diary,” that “forces us to consider midwifery in the broadest possible context, as one specialty in a larger neighborhood economy, as the most visible feature of a comprehensive and little-known system of early health care, as a mechanism of social control, as a strategy for family support, and a deeply personal calling.”⁵³ Ulrich delves into this “interrelationship throughout her reconstruction of Ballard’s domestic and professional life.”⁵⁴ The practice of midwifery was the fundamental expression of Ballard’s civic existence. It also signified her character. As a result, she was always on duty when expectant mothers in her community required help. Ulrich provides an extraordinary breadth of facts and discernment into the life of a midwife and the healing customs of the period.

“Hallowell’s female healers move in and out of sickrooms unannounced,” the author maintains, “as though their presence there were the most ordinary thing in the world—as it was. Historians have been dimly aware of this broad-based work, yet they have had

⁵⁰ Litoff, 950.

⁵¹ Ibid., 950.

⁵² Ibid., 950.

⁵³ Ulrich, 33.

⁵⁴ Greven, 326.

difficulty defining it."⁵⁵ According to Ulrich, "Ballard was one of the most skilled and sought-after midwives in her community, in which 'birth, illness, and death wove Hallowell's female community together.' "⁵⁶ Throughout the twenty-seven years that Ballard kept her diary, she diligently documented each of the 814 births she attended. In her years of practice she witnessed a mere five maternal deaths. The midwife's record is enormously commendable considering that it has only been in the past fifty years that the United States' maternal death rate has been diminished to one lower than Ballard's rate. Ulrich presented a perceptive examination of Ballard's diary. More significantly, she has established that historians have a great deal to discover from the "trivial" writings of "ordinary" women.⁵⁷

In *The Weight of Their Votes*, Lorraine Gates Schuyler provides a fascinating assessment of female voters in the South in the 1920s. She argues that female voters brought about a considerable change in southern politics and civic strategy as they wielded their power as members of a self-determining electorate.⁵⁸

In the 1920 presidential election, numerous southern women cast their ballots for the first time. They tackled a confusing network of literacy assessments, poll taxes, and filthy polling sites. According to reviewer Ann Short Chirhart, "Some white men, predominantly southern Democrats who had opposed woman suffrage, continued to look for ways to block women from voting while African American men supported black

⁵⁵ Ulrich, 61

⁵⁶ Greven, 326.

⁵⁷ Litoff, 950.

⁵⁸ Ann Short Chirhart, review of *The Weight of Their Votes: Southern Women and Political Leverage in the 1920s*, by Lorraine Gates Schuyler, *Collected Book and Web Reviews* (Alexander Street Press, Alexandria, VA, 2005), accessed March 2010, <http://womhist.alexanderstreet.com/schuylerreview.htm>.

women as a means to gain equality for their race.”⁵⁹ Consequently, “as chapters of the National American Woman Suffrage Association began to turn into the League of Women Voters (LWV), some of their first activities were to educate women on registration and their rights as voters.”⁶⁰ Schuyler contends that these crusades to inform prospective voters and challenge dubious voting restrictions strengthened political involvement in the area “by more than one million new voters” and also confronted the custom of disfranchisement.⁶¹ Female voters instantly found “ways to improve the voting process by publicizing registration dates, polling places, and assisting others.”⁶² Before the passage of the Nineteenth Amendment, voting locations were predominately a male environment in which behavior “associated with men accompanied the casting of ballots. Yet, once women began to enter these places to vote, either their presence changed the tone or they started taking exception to the environment and calling for change.”⁶³ In Tennessee when women reached the polling places to cast their ballots, there was undoubtedly a difference in the voting setting. Schuyler states, “loud talking and gambling are absent and everything was orderly as a Sunday school assemblage.”⁶⁴ In addition, occasionally black women managed to take advantage of this phase of shifting “voting definitions to exercise their rights as citizens.”⁶⁵ White males employed brutal tactics against African American men as an attempt to diminish their political

⁵⁹ Ibid., 1.

⁶⁰ Jessica Brannon-Wranosky, review of *The Weight of Their Votes: Southern Women and Political Leverage in the 1920s*, by Lorraine Gates Schuyler, H-Net Reviews: In the Humanities and Social Sciences, November, 2008, 1-2, Accessed March 2010, <http://www.h-net.org/reviews/showpdf.php?id=22929>.

⁶¹ Ibid., 2.

⁶² Ibid., 2.

⁶³ Ibid., 2.

⁶⁴ Lorraine Gates Schuyler. *The Weight of Their Votes: Southern Women and Political Leverage in the 1920s* (Chapel Hill: The University of North Carolina Press, 2006), 20.

influence. According to reviewer Jessica Brannon-Wranosky, however, this became more difficult across gender lines and as a result the numbers of registered black female voters increased. The author argues that “white women were less likely than white men to use violence to uphold disfranchising polling practices, and often, the same held for white men in the presence of white women.”⁶⁶

Because thousands of women registered to vote in southern states, men in the Democratic and Republican Parties were compelled to pay attention to women and try to obtain their support. Black and white women notified both parties that they were determined to be neutral until they decided if they considered the candidate’s platform to be worthwhile. “Women’s organizations like the United Daughters of the Confederacy, the National Association of Colored Women, and the League of Women Voters conducted letter-writing campaigns to politicians at the local, state, and national levels regarding reforms such as the Sheppard-Towner Infancy and Maternity Protection Act, school reforms, child labor, and homes for delinquent children.”⁶⁷ Attempting to protect an unbiased viewpoint, female voters struggled to make elected representatives responsible for their campaign promises and votes as long as they held office. Furthermore, the League of Women Voters consistently maintained reports regarding how politicians voted on topics so that women could make educated selections.⁶⁸

A few women like Viola Ross Napier in Georgia chose to run for public office. The majority of women, however, favored articulating their political views through letter-writing crusades and candidate surveys. This unbiased standpoint required both political

⁶⁵ Ibid., 24.

⁶⁶ Brannon-Wranosky, 2.

⁶⁷ Short Chirhart, 1.

parties to deal with women's interests throughout political campaigns. Their hard work brought about improvements in education, financial support for healthcare, the achievement of child labor restrictions, "and laws to raise the age of consent for young women. Women's interests as voters tended to focus on healthcare, education, and childcare, concerns that their clubs and organizations concentrated on before 1920. Now they had the ability to push more assertively for implementation of reforms."⁶⁹

According to reviewer Brannon-Wranosky, at the end of the 1920s white women were "voting the Democratic ticket out of habit, and politicians were getting tired of bowing to women's groups."⁷⁰ Nevertheless, "political leaders learned by the end of the decade that women voters had a voice, were not afraid to use it, and tracked perceived gender voting patterns out of habit."⁷¹ The author contends that even though many southern male politicians disliked having to flatter white female voters, they knew they had no other choice. Consequently, ten years after the ratification of the Nineteenth Amendment, women continued to have an effect on southern politics.⁷²

This thesis argues that underprivileged African American women throughout Mississippi and the South contributed to the well being of their communities in the field of public health work—one of the few venues open to African American women at the time. The majority of these women became midwives because they saw a need within their community and wanted to help their neighbors. Midwives assisted and cared for birthing women at a time when many community hospitals rejected African American

⁶⁸ Ibid., 1.

⁶⁹ Ibid., 1.

⁷⁰ Brannon-Wranosky, 3.

⁷¹ Ibid., 3.

⁷² Ibid., 3.

women as patients, either due to racism or the women's inability to pay. After the passage of the Hill-Burton Act in 1946, treating poor women, who only a few years prior could not afford the luxury of a doctor, became financially lucrative for physicians. This thesis argues that even after midwives became educated and adhered to strict state guidelines they were robbed of their practice because they infringed on the white medical community's monetarily profitable business.

II: ESTABLISHING SHEPPARD-TOWNER

In *Mother-Work: Women, Child Welfare, and the State, 1890-1930*, Molly Ladd-Taylor links the private lives of women with public activism. Thus, her study depends a great deal on the periodicals and records of the U.S. Children's Bureau. The Children's Bureau, created in 1912 as a sector of the Department of Commerce and Labor, was the first federal organization to be supervised and staffed almost exclusively by women. In the 1910s and 1920s it served as the women's division of the government. Originally created as a research and education agency, the Children's Bureau published and circulated documents on childrearing, led a countrywide birth registration movement, and supervised studies on infant mortality and child labor. In the 1920s, the bureau oversaw the Sheppard-Towner Act, which provided free medical care to pregnant women and their children. The group's published accounts concerning child labor, infant death rates and mother's pensions, in conjunction with the employees' correspondence with working class women, offer the most comprehensive glimpse available into the lives of typical mothers. Reports from the Children's Bureau give a sense of mothers' daily existence and working conditions. In addition, they offer an abundance of information concerning the beliefs and managerial techniques of Progressive maternalists.⁷³

⁷³ Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (University of Illinois Press, 1994), 10.

Throughout most of American history the majority of mothers believed that if a child died due to a family's inability to obtain proper nutrition or medical treatment, it was that family's personal sorrow. Beginning at the turn of the twentieth century however, women began to turn their "private agony into public action, joining with others in the maternalist movement to urge medical professionals and government to assume their share of responsibility for the welfare of the nation's children."⁷⁴ As Children's Bureau chief Julia Lathrop put it, "Science refuses to accept the old fatalistic cry 'The Lord gave, the Lord hath taken away, blessed be the name of the Lord.'"⁷⁵

Hopeful about the potential of scientific motherhood—and troubled by what they deemed to be the hazardous and uninformed customs of conventional mothers—maternalists taught themselves about informed care giving and educated lower-class mothers on modern childrearing practices. They hoped to find a way for all children to have access to the improvements of contemporary medicine and science. The principal and most passionate advocates of scientific childrearing were upper-class white women. "They had the smallest family size and lowest birth rate of any ethnic group, and consequently were more likely to be isolated in the home without the support of female family and friends."⁷⁶ According to one leading maternalist, "No man or woman of even average ability could read some of the admirable books and articles on child study without becoming painfully conscious of the shortcoming in themselves."⁷⁷

By 1914, so many middle class mothers had become involved in public improvement that author Dorothy Canfield Fisher deduced that the exposure devoted to

⁷⁴ Ibid., 20.

⁷⁵ Ibid., 33.

⁷⁶ Ibid., 33.

childrearing had brought about “most matrons” turning “naturally to some phase of similar activity in the community.”⁷⁸ According to Fisher, middle-aged women were making “themselves more useful to the world than ever before by applying to various forms of social uplift the experience, the poise, the knowledge of life, which they have acquired in the years of their mothering.”⁷⁹ Operating within the local community and in the National Mothers’ Congress, middle and upper class women trained themselves about the discipline of childrearing, circulated child development pamphlets to the underprivileged, and became active in governmental affairs regarding the well being of the nation’s children. “Their maternalism was a bridge between mothers and experts, grassroots activists and political reformers, and between traditional and modern concepts of childcare.”⁸⁰

According to Ladd-Taylor, motherhood was a vital organizing standard of Progressive era political principles. Between 1890 and 1920 it developed into an openly political issue, indistinguishably linked with state-development and community strategy. Practically every female advocate employed “motherhood rhetoric, and virtually every male politician appealed to motherhood.”⁸¹ The National Congress of Mothers decided that the twofold objective of maternalism was to educate mothers on how to take care of their own children appropriately and to arouse their maternal conscientiousness to advance societal circumstances concerning all children. “The young mothers have all they can do within the home,” wrote PTA president Hannah Schoff, “but when the birds

⁷⁷ Ibid., 33.

⁷⁸ Ibid., 43.

⁷⁹ Ibid., 43.

⁸⁰ Ibid., 43.

⁸¹ Ibid., 43.

have flown from the nest, the mother-work may still go on, reaching out to better conditions for other children.”⁸² Emphasizing both the private and civic duties of childcare, “Schoff insisted ‘parents can never do their full duty for their own children until they make it their business to see that all children have proper treatment and proper protection.’”⁸³

The National Congress of Mothers and Parent-Teacher Associations, from the time of its founding, perceived itself as an association representing women of all ethnic groups and backgrounds. Articles describing mothers’ clubs in foreign countries, such as Palestine, Persia, China, Mexico, and England, were always included in the *Child Welfare Magazine*. Possibly pointing toward “the abolitionist heritage of a few of its leaders, the Mothers’ Congress also invited some prominent African Americans to speak at its annual meetings.”⁸⁴ At the first conference, author and children’s advocate Frances Ellen Watkins Harper seized the opportunity of the inclusive language of maternalism and presented a lecture imploring white women to treat black women with respect and to assist in financing their mothers’ associations. “Has not the Negro also a claim upon the nation?” Harper implored.⁸⁵ “If you want us to act as women, treat us as women.”⁸⁶

Although the *Child-Welfare Magazine* regularly featured editorials on club mothers’ dealings with immigrants, it contained barely any dialogue concerning Parent-Teacher Association (PTA) efforts by African Americans. According the Ladd-

⁸² Ibid., 43.

⁸³ Ibid., 45.

⁸⁴ Ibid., 56.

⁸⁵ Ibid., 56.

⁸⁶ Ibid., 56.

Taylor, there is no indication of a specific “polity on race in the records of the National Congress of Mothers and Parent-Teacher Associations, but it is likely that, like the General Federation of Women’s Clubs and the National American Woman Suffrage Association, the Congress discriminated against African Americans.”⁸⁷ Even though a few African American women took part in the mostly white PTAs and mothers’ clubs, integrated meetings appear to be uncommon, undoubtedly owing to “racially segregated schools and housing patterns as well as prejudice among white women.”⁸⁸ In the 1920s, a detached group of black mothers’ clubs and parent-teacher organizations emerged. “The National Congress of Colored Parents and Teachers formed in 1926. By 1930, it had 14,000 members. Despite the active role African American women played in mothers’ clubs and PTAs, there is only scattered reference to their activities in the *Child-Welfare Magazine*.”⁸⁹ The little information from African American clubs portray activities nearly indistinguishable from those assumed by white clubs, possibly due to the fact that those proceedings were awarded particular value in a periodical with a circulation that was predominately white. In 1916 for instance, the *Child-Welfare Magazine* stated “that the six members of the Poplarville, Mississippi, Colored Mothers’ Club paid tuition and bought books for orphaned students, furnished wood and crayons for their school, and were beginning to raise funds for a domestic science teacher.”⁹⁰

The understanding of home and motherhood was also an area of contention between white and black members of mother’s clubs. Black and white women consented to “women’s responsibility for childrearing and used maternal imagery to further their

⁸⁷ Ibid., 58.

⁸⁸ Ibid., 58.

⁸⁹ Ibid., 58.

cause.”⁹¹ For instance, Chicago activist Fannie Barrier Williams encouraged all women to “become the civic mothers of the race,” and Ida B. Wells portrayed motherhood as “one of the most glorious advantages of the development of womanhood.”⁹²

Nevertheless, according to Ladd-Taylor, “the realities of mothering in a racist society made it impossible for African Americans to idealize motherhood in the same way as elite whites.”⁹³ For black mothers, the heritage of a slave society, “when motherhood meant producing slave labor and possibly losing one’s children through sale,” and child and maternal death rates were double those of whites, characterized the “maternal experience.”⁹⁴ Mary Church Terrell, who herself lost three children within days of their births, eloquently explained the differences to the National Congress of Mothers:⁹⁵

“Contrast, if you will, the feelings of hope and joy which thrill the heart of the white mothers with those which stir the soul of her colored sister. Put yourselves for one minute in her place, (you could not endure the strain longer) and imagine, if you can, how you would feel if situated similarly—As a mother of the weaker race clasps to her bosom the babe which she loves as fondly as you do yours, her heart cannot thrill with joyful anticipations of the future. For before her child she sees the thorny path of prejudice and proscription which his little feet must tread...So rough does the way of her infant appear to many a poor black mother

⁹⁰ Ibid., 58-59.

⁹¹ Ibid., 60.

⁹² Ibid., 60.

⁹³ Ibid., 60.

⁹⁴ Ibid., 60.

⁹⁵ Ibid., 60.

that instead of thrilling with the joy which you feel, as you clasp your little ones to your breast, she trembles with apprehension and despair.”⁹⁶

Ladd-Taylor believes that upper-class African American women were more prone than whites to recognize their destiny as being connected to that of the underprivileged.

Fannie Barrier Williams described it this way:

“The club movement among colored women reaches into the sub-social condition of the entire race. Among white women, clubs mean the forward movement of the best women in the interest of the best womanhood. Among colored women, the club is the effort of the few competent on behalf of the many incompetent; that is to say that the club is the only one of many means for the social uplift of a race.”⁹⁷

Working as an American activist and social worker, Florence Kelley efficiently petitioned for the enactment of child labor laws and improved circumstances for working women throughout the United States.⁹⁸ In 1926, Kelley reasoned, “Of all the activities in which I have shared during more than forty years of striving, none is, I am convinced, of such fundamental importance as the Sheppard-Towner Act.”⁹⁹ After passage of the suffrage amendment, the Maternity and Infancy Protection Act was the first federally subsidized social welfare undertaking and the first “women’s” legislation ratified. The

⁹⁶ Ibid., 60-61.

⁹⁷ Ibid., 61.

⁹⁸ Kathryn Kish Sklar, *Florence Kelley and the Nation's Work: The Rise of Women's Political Culture, 1830-1900* (Yale University Press, 1995).

⁹⁹ Ibid., 167.

1921 endorsement indicated the pinnacle of the maternalist crusade to generate and manage a welfare structure that sheltered the well being of mothers and children.¹⁰⁰

The Sheppard-Towner Act, sponsored by Representative Horace Mann Tower, a Republican from Iowa, and Senator Morris Sheppard, a Democrat from Texas, outlined by Children's Bureau chief Julia Lathrop, put forth the political perspective and agenda of maternalism: "Maternalists' high regard for mothers' work and service to the state was evident in their call for the government protection of motherhood; their belief that women had a special sensitivity to child welfare was manifest in their insistence that Sheppard-Towner health programs be run by women."¹⁰¹

Maternalists' devotion to every child's well being prompted Sheppard-Towner personnel to broaden the standards of scientific childrearing into all communities and racial groups, even as the maternalist devotion to the family wage structure was mirrored in the proposed law's interest in women solely based on their maternal position. Sheppard-Towner did not, however, defy married women's economic reliance on men or attempt to give power to mothers in additional societal tasks. Its objective was to safeguard the health of women and children inside the family.¹⁰²

Even though the educational programs of the Sheppard-Towner Act did not defy women's dependent standing within the family, Ladd-Taylor contends that the majority of mothers were pleased with the bill. "Those who lacked vital information about reproduction and their bodies, who had suffered a difficult pregnancy or birth, or who had lost a child, were desperate for any information that could give them more control over

¹⁰⁰ Ibid., 167.

¹⁰¹ Ibid., 167.

their health.”¹⁰³ A number of women wrote the Children’s Bureau to convey their gratitude for its effort and to learn how the bill could help them. ““I do hope it will help us Poor Country people who need help,”” a Texas mother wrote ‘I am 27 yrs. old and have Five little one’s to Care for besides my husban[d] and his Father.’”¹⁰⁴

According to Ladd-Taylor, the final version of the Sheppard-Towner Act was significantly ineffectual compared to the original bill presented by Representative Jeannette Rankin and Senator Joseph Robinson in 1918. “The Rankin-Robinson bill provided ‘medical and nursing care at home or at a hospital when necessary,’ as well as instruction in hygiene, and it specifically targeted rural areas, where mortality was thought highest.”¹⁰⁵ In comparison, Sheppard-Towner provided “no hospital or medical care, reduced the Children’s Bureau’s authority over administration,” and harshly slashed appropriations.¹⁰⁶ “Although the original Sheppard-Towner bill requested an appropriation of 4 million dollars, the version that passed allocated only 1.48 million for fiscal year 1921-22 and 1.24 million for the next five years. No more than fifty thousand dollars was given to the U.S. Children’s Bureau for administrative expenses.”¹⁰⁷ Each state received five thousand dollars outright and the government granted an additional five thousand to states that matched federal resources. Moreover, the bill was guaranteed for only eight years, which meant that in 1929 the bill would have to be endorsed yet again.¹⁰⁸

¹⁰² Ibid., 167.

¹⁰³ Ibid., 176.

¹⁰⁴ Ibid., 177.

¹⁰⁵ Ibid., 175.

¹⁰⁶ Ibid., 175.

¹⁰⁷ Ibid., 175.

¹⁰⁸ Ibid., 175.

Nevertheless, the Sheppard-Towner Act was quickly and enthusiastically received by most states. Sheppard-Towner funds were used by states to allow health professionals to make home visits, hold health conferences, promote birth registration, and distribute literature, especially the Children's Bureau pamphlets entitled *Prenatal Care* and *Infant Care*. "A number of states also ran mobile health clinics (called 'child-welfare specials'), organized training programs for midwives, immunized children against diphtheria and smallpox, and encouraged the use of silver nitrate to prevent blindness in infants."¹⁰⁹ Examining community hospitals, day nurseries, and maternity homes and maternal and infant death rates were a few of the uses for Sheppard-Towner resources. "By 1929, the bill's last year of operation, the Children's Bureau estimated that Sheppard-Towner workers held 183,252 prenatal and child health conferences and helped establish 2,978 permanent health clinics."¹¹⁰

One result of the Sheppard-Towner Act was the training of lay midwives. Across the United States as late as 1910, midwives delivered half of all babies. Their practice was primarily among women of white European descent and African American women of the South.¹¹¹ The practice of midwifery was commonplace in Mississippi. Together, black midwives and white nurses would help to implement a new public healthcare structure in Mississippi during the 1920s. Records of the Mississippi State Board of Health together with letters from midwives and public health nurses' reports put midwives at the heart of the story of public health reform. Already held in high esteem by their own communities, midwives came to be more respected by the white community as

¹⁰⁹ Ibid., 177.

¹¹⁰ Ibid., 177.

a result of education and the embrace of new practices. Midwives gradually gained in the estimation of the medical community as well.

In 1921, Laurie Jean Reid, a white nurse with the United States Public Health Service (USPHS), came to Mississippi to study midwives. Reid traveled through Mississippi's eighty-two counties inquiring about midwives and recording the number and names in each county. She found more than 4,000 midwives in Mississippi, and the state identified another 1,000 midwives several years later. Her intention, as she explained to the all-white, predominately male Mississippi Medical Association, was to concentrate on the fact that the United States had higher infant and maternal death rates than most European countries. Reid believed that these high rates were caused by inadequate health care for expectant mothers from "careless physicians and by illiterate and ignorant midwives."¹¹² Avoiding the subject of physician care, she suggested that the state remove any midwives who were diseased or too old for training and register and educate those who remained. Before coming to Mississippi, Reid believed that "targeting midwives was an easier solution for public health officials dealing with an impoverished rural population than criticizing physician care or altering the economic and living conditions that contributed to ill-health."¹¹³ Beginning in the early 1920s, a statewide plan in Mississippi was implemented to inform midwives of each county to report to a designated site for preliminary training. The county health officer was encouraged to be present at this gathering. According to the 1921 survey, ninety percent of the midwives recorded were illiterate, and ninety-nine percent were African American. They were

¹¹¹Susan L. Smith, "White Nurses, Black Midwives, and Public Health in Mississippi, 1920-1950," *Nursing History Review*, no. 2 (1994): 30.

¹¹² *Ibid.*, 32.

untrained by the white medical establishment's standards, but most had served as apprentices to practicing midwives. Many were elderly and frail with superstitious beliefs, ignorant of rules of hygiene, and reluctant to call a doctor for irregular cases. They were also anxious because of the decision to place them under the management and control of the medical establishment. In Mississippi where half of the population was black in the late 1920s, midwives, called "grannies" by white health officials, delivered eight percent of white babies and eighty percent of black babies.¹¹⁴ According to Susan L. Smith, author of "White Nurses, Black Midwives, and Public Health in Mississippi, 1920-1950," "With immigration restrictions and the preference of urban women for childbirth attendance by physicians," midwives in 1930 delivered only fifteen percent of all births in the nation.¹¹⁵ At that time, eighty percent of all remaining midwives practiced in the South.¹¹⁶

In spite of the fact that health officials attributed high maternal and infant death rates to midwives, these women's record for safety was no worse than that of the majority of doctors. Various contemporary surveys illustrated that maternal death percentages were lowest where the percentage of midwife-attended births was highest. In 1923, Nurse Supervisor Lois Trabert of Mississippi's Bureau of Child Hygiene declared: "I firmly believe that when we do get these midwives properly trained, in as far as that is possible, that they will do better and cleaner work than the average country doctor."¹¹⁷

¹¹³ Ibid, 32.

¹¹⁴ James H. Ferguson, "Mississippi Midwives," *Journal for the History of Medicine*, no. 5 (May 1950): 85.

¹¹⁵ Smith, 30.

¹¹⁶ Ibid., 30.

¹¹⁷ Ibid., 30.

By the 1930s, the Mississippi Board of Public Health employed 125 white and 6 black public health nurses to instruct untrained midwives.¹¹⁸

Spiritual women whose gifts were passed from one generation to the next, they understood their abilities to be “a gift from God; the African American description of the midwife’s job as ‘catching babies’ reflects the perception that midwives merely assisted God’s work.”¹¹⁹ While doctors used drugs to accelerate labor and assist in delivery, midwives put their faith in “massage, prayer, and herbal medicine to make birth safer and less painful. ‘Honey, I don’ do nothin’; I jus’ lights my pip an’ waits,’ explained an African American midwife when asked what she did after arriving on the case.”¹²⁰ The curative methods employed by midwives were based on spiritual and emblematic customs. Southern African American midwives “stopped hemorrhaging by serving ginger tea, applying cobwebs and cloths soaked in vinegar or tansy on the abdomen or birth canal, and advised the mother not to change her clothes for several days after birth.”¹²¹

In *The Archaeology of Mothering: An African American Midwife’s Tale*, Laurie Wilkie uses archaeological artifacts found at a trash deposit at a house site in Mobile, Alabama, and, using these materials, examines how one extended African-American family took part in competing and conflicting mothering philosophies in the post-Emancipation South. Following the death of her husband, Lucrecia Perryman trained as a midwife to provide for her family. As a midwife, Perryman became an instrument for conveying intellectual, societal, and political information concerning mothering to her

¹¹⁸ Ibid., 30.

¹¹⁹ Ladd-Taylor, 24.

extensive African-American community. According to Wilkie, “the vast numbers of medically related artifacts” discovered at the trash deposit “suggested that Perryman had dumped much of her ‘tool kit’ following retirement.”¹²²

“Although feminist historians became interested in the experiences of African American midwives and conducted several oral history projects, interviews were with women whose practices had been shaped by the period of regulation, not those who came before.”¹²³ In 1925, fourteen years after Lucrecia’s retirement, the state of Alabama regulated the practice of midwifery. The materials discovered at the Perryman house site consequently afford a unique opportunity to investigate pre-regulation midwifery, specifically a channel of researching a distinct ethnomedical practice.¹²⁴

Midwifery is a powerful example of what Patricia Hill Collins has termed motherwork. “Work for the day to come is motherwork, whether it is on behalf of one’s own biological children, or for the children of one’s own racial ethnic community, or to preserve the earth for those children who are yet unborn.”¹²⁵ According to Wilkie, “motherwork was the work of creating mothers.”¹²⁶ Midwives did not merely “catch babies” but educated women about how to be mothers. In the postpartum period, midwives spent a great deal of time with the new mother, instructing her how to nourish, bathe, and look after the baby. Magical and medicinal ceremonies guarded the baby from sickness and malicious spirits. “In teaching the basics of motherhood, midwives actively

¹²⁰ Ibid., 24.

¹²¹ Ibid., 24.

¹²² Laurie A. Wilkie, *The Archaeology of Mothering: An African-American Midwife’s Tale*. (New York: Routledge, 2003), xvi.

¹²³ Ibid., xviii.

¹²⁴ Ibid., xviii.

¹²⁵ Ibid., 119.

¹²⁶ Ibid., 120.

modified the traditions of one generation to suit the new realities of the next, combining cultural conservatism and innovation in their practices.”¹²⁷ The aptitude of midwives to cope with the transforming needs of modern generations promoted continuities in ethnic traditions and values.¹²⁸

One of the most interesting aspects of Wilkie’s research is her aptitude for discovering meaning in the materials found at the Perryman’s house site. Whiskey is frequently identified in oral histories as a main ingredient in “home remedies.” Besides “the chemical properties of alcohol that make it an appropriate medicinal base, African American informants have described at length the use of whiskey or ‘spirits’ in a wide range of magical cures, including the creation and feeding of charms, and as elements of potions.”¹²⁹

Among the earthenware containers discovered at the Perryman house site are twenty-five one-gallon or larger ceramic “whiskey jugs” and twenty-five ceramic gin bottles. Fifty-one liquor bottles and flasks were also salvaged. All of the ceramic decanters correspond in form and design to those used throughout the region at the turn of the twentieth century to store whiskey, and none display the characteristic spout that commonly distinguished molasses containers. Even though it is not possible to identify if these containers were obtained full of alcohol or if they were acquired empty and filled with a different liquid, the discovery of numerous containers implies that Perryman amassed large amounts of alcohol. “The limited oral historical and ethnographic materials available on pre-regulation midwifery do discuss the importance of homemade

¹²⁷ Ibid., 121.

¹²⁸ Ibid., 121.

¹²⁹ Ibid., 126.

pharmaceuticals to a midwife's tool kit."¹³⁰ Additionally, according to the author, "midwives have been tied not just to the use of alcohol in these remedies, but also to the production of 'moonshine.'"¹³¹ Wilkie interviewed a woman who recalled that a North Carolina midwife who practiced throughout the early twentieth century had her own still for the production of medicinal cures. "During Prohibition, she was able to continue her midwifery practice by providing local authorities with free 'hooch.' The large number of whiskey jugs curated by Perryman may be indicative of medicinal production and storage at the site."¹³² Considering the number of flasks retrieved as well as the decanters, Wilkie believes that jug whiskey was employed in Perryman's curative practice, while the flasks were used for family consumption.¹³³

Among the jugs discovered at the house site are 10 "Sauer's Extracts" containers. "Extracts, such as essence of peppermint, lemon, ginger, and vanilla, were sold both for cooking and as ingredients in medicinal remedies. The presence of these bottles further suggests that Perryman was producing medicines."¹³⁴ Peppermint especially "was an important ingredient in many African American magical and medicinal cures."¹³⁵ According to African American legend, peppermint washed onto the front steps of a house is supposed to attract good luck; placed on the hands, it leads to love and friendship; and, when added to therapeutic teas, eases various stomach ailments.¹³⁶

The house site also produced evidence that Perryman might have been preparing food remedies because faunal remains were discovered at the site. Beef cuts at the trash

¹³⁰ Ibid., 126.

¹³¹ Ibid., 126.

¹³² Ibid., 126.

¹³³ Ibid., 126.

¹³⁴ Ibid., 126.

¹³⁵ Ibid., 127.

deposit were taken, almost entirely, from the head and lower appendages, parts with the least amount of meat. “The presence of cranial elements, teeth, and fragments of mandible suggest that the Perrymans may have been boiling down cows’ head, similar to the way that pigs head are boiled to make hogs’ head cheese. The lower portions of the cows’ legs provide little in the way of meat.”¹³⁷ These portions of the foot might be connected to Perryman’s midwifery practice. One foodstuff recommended for sick people that make use of a cow’s lower extremities is calf’s foot jelly, which was prepared by boiling limbs to deteriorate the cartilage and other connecting tissues to edible form. “Before the development of commercial gelatin, any molded dessert or salad relied upon the jelling properties drawn from calves’ feet. The gelatin was prepared by gently boiling calves’ feet in water, skimming the surface when necessary, and draining the particles.”¹³⁸ According to Wilkie, midwives commonly used cow hoof teas to treat menstrual cramps.¹³⁹

Women often became midwives because their relatives were midwives, and because they wanted to make a positive contribution to their communities. Olivia Jefferies’ aunt, Lillery Knox, was a midwife in New Albany, Mississippi, located in Union County in the hill country of northeast Mississippi. At the time, Union County had a population of 20,262.¹⁴⁰ One day in 1949 when Mrs. Knox was about to deliver a baby, she said to eighteen year-old Olivia that “she did not want to ride by herself. And

¹³⁶ Ibid., 127.

¹³⁷ Ibid., 129.

¹³⁸ Ibid., 129.

¹³⁹ Ibid., 129.

¹⁴⁰ Richard L. Forstall, “Mississippi Population of Counties by Decennial Census: 1900 to 1990” (Population Division US Bureau of the Census, 1995) [database online]; accessed April 16, 2006, available from <http://www.census.gov/population/cencounts/ms190090.txt>.

she lived in the flat.¹⁴¹ She lived right up from me. So I say, ‘I’ll ride with you.’ And she said, ‘O.K.’ And when I get there she made me help her deliver them babies. And she said, ‘you old enough to know, cause you already got a child.’ She say, ‘it’s time for you to learn how to be a midwife because you have to do this for a living.’”¹⁴² According to Mrs. Jefferies, she learned to be a midwife because she wanted to help people.¹⁴³

By 1947, midwives attended 23,815 or 36% of the women who gave birth in the state. The midwives, totaling 2,192, only thirty-five of them white, played a large part in the protection of maternal well being in Mississippi. The guidelines, instruction agenda, and certification of midwives by the State Board of Health added to the forty-seven percent decline in the maternal death rate by 1937. In 1947, fifty-eight percent of the births in Mississippi still took place in the home. In a number of counties, midwives attended the majority of white women due either to the shortage of doctors or by preference.¹⁴⁴ Black women, and some white women, favored midwives over physicians for monetary and cultural reasons. Midwives were less expensive than doctors and were willing to journey to isolated areas. They offered reassurance and assistance for expectant women before, during, and after delivery. Many midwives even took care of the cooking and cleaning as well as caring for the mother and newborn.¹⁴⁵ According to Dr. David Ellis of Union County, Mississippi, the midwife who delivered his twin daughters stayed with his family for a couple of weeks to care for the newborns until his

¹⁴¹ The “flats” is the backwater, low ground area at the edge of the Tallahatchie River in New Albany, Mississippi. African Americans occupied it predominantly

¹⁴² Olivia Jefferies, interview by Elizabeth Payne, September 8, 2005, Union County Historical Museum, New Albany, Mississippi, transcript.

¹⁴³ Ibid.

¹⁴⁴ Ferguson, 85.

¹⁴⁵ Ibid., 85.

wife was healthy enough to take over the duties. The twins were born in 1949, six years before Ellis finished his medical training. According to Mrs. Ellis:

“This midwife came and stayed with me for a week or two weeks, and she took the babies in the living room. She slept on my couch. She moved the babies in the living room with her. If someone called her to deliver a baby, she’d go deliver it and come back. She didn’t leave us for a long time.”¹⁴⁶

Numerous women chose delivery by another woman, particularly one with a reputation for skillful service. In addition, many rural women chose midwives over doctors because midwives treated poor, rural women with dignity rather than disregard. Anne Lettieri, a white woman born in Lee County, Mississippi, in 1938, was the daughter of a midwife. Mary Gertrude Williams was born in 1908 in Itawamba County, Mississippi. In 1951, at only fourteen years old, Lettieri remembers, unbeknownst to her mother, following her mother and peeking through the window of the house while her mother attended a laboring woman. Lettieri stated: “That poor farm woman didn’t even have an aspirin in the house—nothing for pain. She didn’t even have towels. Mama had to go to a neighbor’s house to borrow rags to clean up the mess.”¹⁴⁷ Often hospitals, such as the one in Union County in 1949, did not deliver black babies. According to Mrs. Jefferies, the hospitals did not want to deliver black babies. “They say you can have a midwife or either you can go somewhere else and have a baby, and so they just called on the midwife.”¹⁴⁸

¹⁴⁶ David Ellis, interview by L. Lane Noel, October 27, 2009, New Albany, Mississippi, video recording.

¹⁴⁷ Anne Lettieri, interview by L. Lane Noel, September 28, 2010, Verona, Mississippi.

¹⁴⁸ Jefferies, 2005.

Since they thought they were doing the work of the Lord, African American midwives in Mississippi did not insist on compensation, although a few dollars or payment in kind such as a gift of pigs was standard. One woman whose husband was unable to meet the cost gave her cow to the midwife who delivered her child.¹⁴⁹ In the 1920s, Mississippi midwife Bessie Sutton received around \$1.50 for a delivery, and when she retired “in 1962 the fee had increased to \$20.”¹⁵⁰ She made it clear that she worked because she loved people, not for the money. She stated, “If I’d a stopped ‘cause they didn’t pay me, I’d a stopped a long time ago.”¹⁵¹ Mrs. Jefferies said that her aunt, who was also a midwife, charged about twenty dollars for each delivery. Mrs. Jefferies stated: “[Be]cause you be going be getting up. You liable to get up at twelve o’clock, you liable to get up at one o’clock, you liable to go and stay all night long, or you liable to go and stay two days. You making it, twenty dollars. And that’s how she made her living. And I jumped in and started helping.”¹⁵² However, if the family did not have the money, Mrs. Jefferies said, “we just deliver the baby and go home.”¹⁵³ According to Mrs. Jefferies, she as well as her aunt returned to the home to check on the mother and baby. If they were not doing well, they nursed the baby and mother for however long it took for recovery. All these services were included in the twenty-dollar fee.¹⁵⁴

Midwives were known for being devoted to the communities they served. Sherra Owen, a white woman who was born in rural Union County in 1943 and taught home economics in New Albany during the 1960s and 1970s, recalls the story of a local

¹⁴⁹ Ferguson, 197.

¹⁵⁰ Smith, 31.

¹⁵¹ Ibid., 31.

¹⁵² Jefferies, 2005.

¹⁵³ Ibid., 2005.

midwife she refers to as “Aunt Hattie.” Mrs. Owen remembers from her childhood seeing the midwife travel daily into New Albany to make herself available for deliveries. After her mule died, Mrs. Hattie Stone walked the ten miles into New Albany every day carrying a walking cane with a red bandana tied to it. In the bandana she carried lemon drops to give to children while she sat in front of the courthouse waiting for anyone who needed her to “bring babies.”¹⁵⁵ Occasionally, due to bad weather, physicians found it impractical to get to all cases because of poor roads. On those occasions, there was no choice but to call the local midwife.

¹⁵⁴ Ibid., 2005.

¹⁵⁵ Sherra Owen, interview by L. Lane Noel, April 5, 2006, Union County Historical Museum, New Albany, Mississippi, video recording.

III: RESULTS OF SHEPPARD-TOWNER

Black midwives and white nurses together helped to implement a new public health care structure in Mississippi. As midwives came under state guidelines beginning in the early 1920s, the state used midwives as the vital link to the African American community. Supervised by public health nurses who were in charge of instruction, black midwives played a pivotal role in the state's efforts to "modernize" public health practices. Involvement of the state into the previously unregulated practice of midwifery meant the formation of a department that negotiated between the state and authorized midwives as well as those midwives deemed unqualified to practice and therefore vulnerable to prosecution. Whether or not midwives abided by the new system, the state put restrictions on the health services midwives were permitted to carry out during childbirth as well as other healing practices.¹⁵⁶

Records of the Mississippi State Board of Health together with letters from midwives and public health nurses' reports put midwives and nurses at the heart of the story of public health work. In 1994, Smith wrote that, "Nurses, most of whom were white, and midwives, most of whom were black, worked together to implement the modern public health care system in Mississippi."¹⁵⁷ Paradoxically, the state regulation of midwifery that brought public health nurses in close contact with lay midwives led to the formation of an unforeseen cadre of public health workers for the state. Beginning in

¹⁵⁶ Ibid., 31-32.

¹⁵⁷ Ibid., 29.

the 1920s, Mississippi endorsed limitations on midwifery practice as health officials alleged that midwives did not maintain sanitary surroundings and that they used unscientific and therefore hazardous folk medicine. Nevertheless, health officers and public health nurses quickly realized that midwives afforded indispensable assistance in applying health policy in African American communities. According to Dr. David Ellis, who practiced medicine in Union County, Mississippi from 1955 to 1995,

“I’ve seen midwives that you could trust with just about anything you could do yourself. They filled in a space where there was no one, and a lot of babies lived because of the midwife that would have died without the midwife. The midwives didn’t have anesthesia, didn’t have surgery, didn’t have this, that, and the other, but they did an excellent job.”¹⁵⁸

Although health officials never regarded midwives as their equals, they often noted midwife contributions to public health work.

A State Supervisor of Midwives coordinated the midwives of Mississippi for the first time in 1921-1922. This statewide plan was an innovative attempt to decrease maternal and infant mortality rates. Before state management, a midwife performed deliveries as she had witnessed older midwives and her neighbors perform them. Yet, her knowledge of modern medicine more often than not consisted of only a meager understanding of the relationship that existed between her and the neighborhood doctor. Midwives called a doctor only when the patient was in apparent abnormal pain.¹⁵⁹

¹⁵⁸ Ellis, October 27, 2009.

¹⁵⁹ Ferguson, 85.

As the work advanced and different needs became evident, a public health nurse was sent first to those regions where the groups of midwives were the largest and where the need was the most obvious to stay for an adequate period of time to carry out a rigorous course of training. Beginning in the 1920s, the state required midwives to have monthly club meetings where they were to expand their knowledge. As an alternative to holding county meetings where a large group of midwives was present and it was possible to touch only lightly on assorted stages of the vocation, midwives were separated into community groups and organized into clubs. Each club had a director and a secretary taught by the public health nurse to carry on the midwife club after the original instruction.¹⁶⁰

The Midwife Club was the association that provided a self-sufficient course of education for the midwife. Each county or district within the county had a Midwife Club that met on a regular basis, usually monthly. In 1950, there were 410 of these clubs actively engaged in work in the state of Mississippi.¹⁶¹ By being present at these gatherings, the midwives stayed focused, and their knowledge remained up to date.¹⁶² The African American leader of the Midwife Club was responsible for arranging a comfortable place for the club to meet, directing the meeting, scrutinizing the midwives' bags and fingernails, and supplying the silver nitrate eye drops to prevent blindness in newborns caused by passing through the birth canal of the mothers infected with gonorrhea. Her other tasks included teaching new members the Midwife Song, sending an account of the meeting to Jackson, and leaving the location orderly after the meeting

¹⁶⁰ Ibid., 87-88.

¹⁶¹ Ibid., 88.

concluded. The secretary's responsibilities included keeping the minutes, calling the roll and recording those present and absent, helping to write the birth certificates, reading the midwife's manual to the group, and writing a report of the meeting.¹⁶³

If there was a county nursing service, the work was incorporated into the general public health program, which included continuation of the midwife club with a leader under the guidance of the public health nurse. If there was no nursing service in the county, the headquarters monitored the conduct of the club. In all counties, midwife club leaders received straightforward and unambiguous instructions pertaining to an assortment of phases of the work that they analyzed at club meetings, and then they sent in a written account of the meeting. Whether or not there was a nursing service, midwives felt accountable for the successful management of the midwife club.

Keeping in mind existing conditions and a feasible plan to develop the work, the state developed an outline that dealt with the fundamentals of midwifery. Due to the lack of education available to most midwives, public health nurses gave directions in simple details. Instructions enhanced by demonstrations were given at the customary midwife club meetings to small groups of midwives. Two chief activities were emphasized: sanitation of utensils and personal and home cleanliness of the midwife and future mother and calling a doctor for any irregularity before, during, or after delivery. The public health nurse who made home visits to midwives, prospective cases, and to registrars augmented these lessons by spending "from ten to twenty minutes of her first visit at the

¹⁶² State Board of Health, 5.

¹⁶³ *Ibid.*, 6.

club meeting giving instructions or demonstrations.”¹⁶⁴ Midwife record cards documented a full history of each midwife and included confirmation of her attendance at conferences, readiness to follow directions, a log of her equipment, and the advancement she was making in her work. Furthermore, the record card noted the midwife’s physical assessment, blood test, treatment, and all contacts.¹⁶⁵

The leaders of the midwife club received materials for teaching which included information on how to look after the mothers, infants, and midwives, decrease maternal and infant fatalities and illness, and make midwives more capable. Leaders were also provided information on how to explain the state requirements for practicing midwifery. Other instructions included correctly recording all births and teaching the limitations of midwifery as well as instructing the midwife to communicate with the county health official, doctors, neighborhood registrars, and public health nurses. Preventing loss of sight in a newborn, raising awareness in the areas of maternal and infant care, impressing relatives with the value and first-class treatment of the mothers, and arousing interest for the individual and public health were also important for training midwives. The public health nurse, in addition, had the responsibility of explaining to midwives their obligation to their communities. A midwife should be a teacher of health in her neighborhood and a model for others. She was someone who was in good physical condition, sympathetic to patients, capable and eager to adhere to training, and of a jolly nature with the aptitude to foster a style that stimulated the confidence of her patients and neighbors. The father was also to be included in the delivery plans. If the father understood the needs of the mother,

¹⁶⁴ Papers of Mississippi State Board of Health “Lesson Outlines”, (Jackson, Mississippi: Mississippi Department of Archives and History), Box 2.

he was more inclined to be able to care for the mother and to encourage other family members to do the same.¹⁶⁶

There were other imperative conditions necessary for the improvement of the midwife organization, and a certificate of practice was awarded only after specific fundamental details were adequately inspected.¹⁶⁷ A prospective midwife was interviewed for age, state of mind, appearance, aptitude, and education. Other considerations were a prospective midwife's home and standing in the community. The need for a new midwife in the area was taken into consideration. Local physicians were consulted as to need, and the potential midwife had to acquire a reference from a doctor serving her region. Furthermore, the potential midwife had to have a physical assessment by her medical doctor or county health officer. The examination included a chest X-ray, blood test, and an assessment of the potential midwife's eyesight. Each midwife was required to have an immunization against smallpox and typhoid. All remediable imperfections that would endanger her in her practice or jeopardize others were to be corrected at the midwife's expense. All midwives underwent routine blood tests in even years, and chest X-rays in odd years.

Nurses paid attention to midwives' health, worrying that they would spread illness to birthing women and newborns. The nurse required the midwife to have a Wasserman test for syphilis. If the midwife's syphilis test was positive, she had her permit briefly annulled, and the midwife had to go through treatment and have a

¹⁶⁵ Ibid., 2-3.

¹⁶⁶ Ibid., 2-3.

¹⁶⁷ Ferguson, 87.

physician decide when she could once again safely perform deliveries. In 1928, Nurse McDaniel testified that “the one who had a positive Wasserman is taking treatment regularly and we hope we can give her a permit before long. She asks about her permit each time she comes in.”¹⁶⁸ The midwife’s medical examination results were reported to the Division of Public Health Nursing. The prospective midwife was also required to attend midwife club meetings, classes, and study courses to become scrupulously familiar with the Manual for Midwives. The county health officer and nurse decided when she had acquired this knowledge. In addition, she had to attend at least three deliveries where a doctor and other midwives were present.¹⁶⁹

Midwife meetings had explicit spiritual dimensions. Frequently, midwives held their gatherings in churches, one of the few community buildings controlled by African Americans in rural districts. Furthermore, midwife leaders managed the conventions like a church service, complete with commencing with prayer and a song, a recitation from “the Book,” or midwife manual, and singing the midwife songs. In the Prayer for Midwives, they asked, “Thee teach us to do our job well, in order that each mother will have her baby, and each baby its mother, and that they be well and happy.”¹⁷⁰ Midwife songs included “Protect the Mother and Baby,” sung to the melody of “Mary Had a Little Lamb,” which had hand motions to go along with the lyrics describing the significance of sanitary clothes, clean hands, and immaculate midwives. In 1937, John Lomax, curator of folk songs at the Library of Congress and a native Mississippian, documented a dozen

¹⁶⁸ Smith, 37.

¹⁶⁹ Papers of Mississippi Board of Public Health, “Policies Regarding Midwife Supervision,” (Jackson, Mississippi: Mississippi Department of Archives and History, 1948), 1-2.

¹⁷⁰ Smith, 36.

midwives singing such songs at the Mississippi State Board of Health.¹⁷¹ Lomax, a revolutionary folklorist and musicologist, wanted “to record traditional art forms that he saw as endangered by the widespread acceptance of popular music and the influence of radio and record players.”¹⁷²

At these Midwife Club Meetings, uniform equipment was greatly emphasized. If a midwife could “not learn to assemble the equipment, care for it properly, and understand the use of each article,” the state felt she was unfit to do the work.¹⁷³ If a midwife wanted to practice, she was required to have certain utensils and be able to care for them appropriately. Using the Midwife Manual as a guidebook, the public health nurse would thoroughly explain the care and purpose of each item. An outer leather bag was used to shield the inside bag, and to carry the midwife’s utensils. An inner bag was “one yard domestic, five pockets on one side of the inside of the bag, two pockets on the other side of the inside of the bag, and made with a drawstring.”¹⁷⁴ The state recommended that midwives have two bags so they could switch hurriedly between each delivery and be ready for the next call. The inner bag was also supposed to be starched, placed inside the leather bag, and hung high on a wall so that it would not become contaminated. A head cloth, made from three-fourths of a square yard of domestic cloth was to be used to completely cover the head of the midwife. This was put on before preparing the delivery room, the bed, and the patient. The Midwife Manual contained a pattern for the mask that midwives were required to wear. Immediately before the

¹⁷¹ Ibid., 36.

¹⁷² “Southern Mosaic: The John and Ruby Lomax 1939 Southern States Recording Trip,” *American Memory* (American Folklife Center, Library of Congress, 1999) [database on-line]; accessed April 16, 2006, available from <http://memory.loc.gov/ammen/lohtml/lohome.html>.

¹⁷³ State Board of Health, 4.

delivery of the baby, the midwife put on the mask. The midwife's gown had to be long enough to cover her entire dress. It needed a thin band, short sleeves, to be open down the back, connected with tapes, and put on when the patient went to bed. In the midwife bag, the gown, mask, and head cloth were to be enfolded together.¹⁷⁵

A funnel and tube were to be placed in a domestic bag that was seven to twelve inches long, with a drawstring, washed carefully, boiled in the bag, hung up to dry, and it was not to be opened until it was about to be used. The rectal tube had to be "number 22 at the drug store," and the aluminum funnel could be purchased at a five and ten cent store.¹⁷⁶ The midwife bag also contained soap and a brush, used only to scrub the midwife's hands. A wooden stick with which to clean her nails, and Lysol used to make Lysol water to soak the midwife's hands and to wash the external areas of the mother before and after giving birth and during the lying in phase after a bowel movement or urination could also be found in the midwife bag. Scissors with rounded ends were to be boiled before and after each use. Cord tape was for tying the infant's umbilical cord. Eye drops, acquired from the Midwife Club leader, and a mouth thermometer were also necessities of each midwife. In the midwife bag, the midwife carried birth certificates and the Midwife Manual with her permit inside.

At least twice a year every midwife was required to set up a delivery room, as depicted in the Midwife Manual, in her residence and in the residence of a neighbor. Because it was probable that attendance would be better, the state suggested that the most appropriate time for the delivery room to be set up was "after the cotton is chopped and

¹⁷⁴ Ibid., 4.

after it is picked.”¹⁷⁷ The midwife was to announce the date and the location no less than two weeks before the event. Not only did the midwife present the space to the guests, but she also described the need for such preparation. A pencil and paper were supplied for guests so they could record what they thought of the exhibit. A description was sent to the state supervisor of midwives in Jackson, the state capitol, so that a precise account of the number of rooms set up in each county in Mississippi could be documented. These displays were an ingenious method to guarantee that midwives understood state regulations, and they provided exposure to white and black individuals concerning the state health board’s work with midwives. Plantation owners, physicians, teachers, insurance agents, students, mothers, and tenant farmers all were present at the delivery room presentations. This demonstration taught the midwives how to set up a delivery room, and it educated mothers to be aware of what they needed to prepare for giving birth. Fathers discovered the necessities required for the delivery, and guests would think about high-quality treatment for mothers and their children. “As the visitors talk about the display, the midwife is stimulated to do better work.”¹⁷⁸ The delivery room was expected to be a painstakingly prepared, sanitary bedroom with newspapers placed on the floor, a paper pad laid out on the bed with a drip sheet leading into a pail, and ample heating and lighting.¹⁷⁹ When the public health nurse scrutinized the room, she was required to review meticulously whether the midwife had abided by the outlines in the Midwife Manual down to the smallest detail, such as placing blocks under the legs of the

¹⁷⁵ Ibid., 4.

¹⁷⁶ Ibid., 4.

¹⁷⁷ Ibid., 6.

¹⁷⁸ Ibid., 7.

¹⁷⁹ Smith, 38.

bed and a board under the bedsprings.¹⁸⁰ A substantial number of midwives fulfilled the demonstration requirements. In 1934, for instance, more than 1,300 midwives mailed in information about their model delivery rooms.¹⁸¹

Investigating the health work of midwives reveals the momentous contributions made by underprivileged African American women to the effectiveness of state health programs. Midwives aided nurses and other health educators in their efforts to persuade women to obtain prenatal and postnatal medical assessments. Midwives also endorsed health centers and inoculation programs.¹⁸² They appropriately perceived themselves as vital links between black communities and white health specialists. In 1939, a midwife appealed for the local public health nurse to attend to a sick woman. Estelle W. Christian informed Nurse Viola M. Jones—both were from Claiborne County—that a woman had approached her at the home where she had recently delivered a baby. The woman had lesions on her arms, legs, and buttocks. The midwife explained to the woman that because she might transmit a disease to the new mother and baby, she could not visit them. Subsequently, the woman informed the midwife that the people across the road from her had identical symptoms. Ms. Christian sent a letter to the local nurse asking her to check on these people. The midwife wrote:

“I made a lecture on the fourth Sunday in August at a church; to the people about their health...I advised them if they had any sores or the least suspicion they were infected with that dreaded disease syphilis to please tell someone before it is too late. So she says she heard me talk that day and when she heard I was in the

¹⁸⁰ State Board of Health, 7.

neighborhood she came to tell me about it. So I advised her to stay at home until I talked with you. So if you could come out here one day I could go to their homes with you.”¹⁸³

Public health nurses and midwives developed a relationship in which midwives supported the work of nurses while nurses in turn supplied midwives with instruction. Health reform in Mississippi arose from this dynamic relationship linking public health specialists, midwives, and patients.¹⁸⁴

By persuading expectant mothers and other people in the area to have their blood tested, midwives helped with controlling venereal disease. These diseases, particularly syphilis, posed a serious public health threat throughout the area from 1920 to 1950. Midwives proved to be extremely valuable in contacting people. For example, in 1944, several nurses speculated as to why attendance at a venereal disease treatment center was unexpectedly rising. They quickly discovered that “a leader of a midwife club who had received literature on syphilis had made talks at churches, schools, and in the homes. This midwife was instrumental in sending in several young girls under sixteen years of age who had infectious syphilis.”¹⁸⁵

As community leaders, midwives’ support of public health ventures contributed to neighborhood cooperation. Midwives supported health department endeavors to protect African Americans from diphtheria and typhoid fever. They endorsed this preventative

¹⁸¹ Ibid., 38.

¹⁸² Smith, 29.

¹⁸³ Ibid., 39.

¹⁸⁴ Ibid., 29-30.

¹⁸⁵ Ibid., 39.

effort at their midwife club conferences, churches, and schools. In 1931, Nurse Ethel B. Marsh of Adams County revealed that her county funded an anti-diphtheria movement among black babies and preschool children. She explained that “the midwives in the various sections of the county are assisting by informing parents of the various stations and dates on which toxin-antitoxin will be given.”¹⁸⁶ Nurse Nell E. Austin from Forrest County pointed out,

“The midwives are very helpful in getting the colored people immunized against typhoid fever. At the last midwives meeting they were asked to round up all the children in their neighborhoods and bring them to the health department and have them inoculated against typhoid fever. One midwife was in the office the very next morning with fifty-five children.”¹⁸⁷

Parents identified with and had faith in their community midwives. Thus, the midwives’ sanctions of these health services made parents more likely to allow their children to partake in state health programs.¹⁸⁸ The *New Albany Gazette* reported in 1941 that “Many mothers’ and babies’ lives have been saved in recent years because the public generally is learning more about how to care for prospective mothers and how to prevent much needless infant and maternal mortality.”¹⁸⁹

Not only did midwives help with certified health department initiatives, they also effectively coordinated their own. They had May Day programs on child health care and participated in the yearly Negro Health Week courses. In 1935, one midwife from Smith

¹⁸⁶ Ibid., 40.

¹⁸⁷ Ibid., 40.

¹⁸⁸ Ibid., 40.

County recounted that at their May Day program “a talk was given about the care of the teeth. A few weeks later the peddler who sells extracts, spices, and tooth paste asked the leader of the midwife club what in the world had caused so many of the people in the community to buy tooth paste.”¹⁹⁰

A few of the nurses’ directions conflicted with revered midwifery practices and consequently led to opposition by the midwives. For instance, nurses were adamant that midwives deliver babies on the bed instead of the floor. “Mothers and midwives particularly opposed this restriction since many women felt the urge to walk around during labor and found it more comfortable to deliver in a squatting position, assisted by gravity.”¹⁹¹ In addition, “some midwives preferred to keep the bed clean and have all the mess on the floor.”¹⁹² One midwife pointed out, “when you in misery, if there is any way you can ease that misery, you gonna ease it.”¹⁹³ Midwives learned that some positions that worked for one woman may not work for another. According to Mrs. Macy Ferrell, born in Lafayette County in 1915, she preferred to deliver her children while she was standing. Mrs. Ferrell also remembers that one woman she knew gave birth to all of her children while “sitting on a slop jar.” Midwives, she thought, had an unerring sense of which position worked best for an individual woman.¹⁹⁴

¹⁸⁹ *New Albany Gazette* (New Albany), May 2, 1941.

¹⁹⁰ Smith, 40.

¹⁹¹ Ibid., 40.

¹⁹² Ibid., 40.

¹⁹³ Ibid., 34.

¹⁹⁴ Macy Ferrell, interview by Elizabeth Payne, December 8, 2005.

In spite of objecting to some of the state regulations, the African American midwives proved intelligent and eager to learn “the white folks’ way.”¹⁹⁵ Midwives became well informed, educated women concerned with the betterment of their communities.

“The old Negress in dirty nondescript dress, a pipe stuck in her mouth, and a few odds and ends of equipment thrown into a paper shopping bag or a drawstring cloth sack began to be replaced by a cleaner woman in a white starched dress and a white cap carrying a neat black leather bag which contained a carefully scrutinized set of supplies.”¹⁹⁶

According to Smith, scholars have confirmed the significant position African American midwives held in their communities “in cultural transmission and community leadership, as well as in health care.”¹⁹⁷ Likewise, Ulrich found that in late eighteenth century Maine, midwifery was the most highly paid work that women could do. White women in factories in 1960 made only \$1.00 an hour in New Albany. Martha Ballard’s customary fee of six shillings is equivalent to what her husband Ephraim could make in one day working as an appraiser of assets.¹⁹⁸ Similarly, Francis Cox remembers that her mother’s profession as a midwife gave her a degree of independence. Charity Hamblin, a white midwife born in Union County in 1889, “knew she could take care of herself, and

¹⁹⁵ Smith, 86.

¹⁹⁶ Ibid., 86.

¹⁹⁷ Ibid., 31.

¹⁹⁸ Ulrich, 199.

she'd tell Daddy, 'You just walked into a home I had already made on my own.' And he did, but that made me so mad because he worked hard.”¹⁹⁹

Midwives were greatly esteemed, prominent members of the communities they served, even though they were at the bottom of the medical hierarchy. From the nineteenth century into the 1960s, black midwives in Mississippi were the female equivalent to preachers as the most prominent members of their communities. They were at the core of the time-honored healing networks in rural African American communities of the South and served as counselors and spiritual leaders. Even though midwives became knowledgeable, well-informed individuals, some superstitious beliefs remained. A knife under the bed, some midwives believed, would slice the pain in half, and the husband's hat donned by the laboring woman would quicken the birth.²⁰⁰

Midwifery was merely a fraction of the work these women performed; the majority of midwives also cared for their own families, cultivated crops, and toiled as domestic servants or teachers.²⁰¹ Mrs. Jefferies remembers, “I'd go and iron, you know, white people's clothes—to they house and leave my children there and my auntie would see at 'em or maybe my cousin next door.”²⁰² Charity Hamblin's husband, Virgil, disliked his wife's work as a midwife because it took her away from her home and family. Nevertheless, according to Hamblin's daughter, “she didn't pay it no mind because she knew she was going. She was independent so to speak. She had the attitude that she didn't have to give too many excuses either.”²⁰³ Being a midwife “was

¹⁹⁹ Francis Cox, interview by L. Lane Noel, November 19, 2009, Union County, Mississippi.

²⁰⁰ Ferguson, 85.

²⁰¹ Smith, 31.

²⁰² Jefferies, 2005.

²⁰³ Cox, 2009.

something good, and something she liked so why should he complain? But he just wanted her there taking care of the family, that's what he wanted. But she didn't go off too much.”²⁰⁴

Although midwives appeared to take pleasure in the chance to mingle with each other, sing together, and impart stories, they were not always able to attend every midwife gathering. Attendance was constantly down during times of intense field labor and when weather conditions made travel arduous, particularly for women who had to trek several miles to the meetings. In 1923, Nurse Agnes B. Belser stated: “I have had but one midwife meeting as they begged off because of the cotton picking season.”²⁰⁵ Another nurse, Louise James, declared that her “greatest trouble in having a full attendance was caused by this season being cane grinding season and most all old women are used to skim cane syrup. Very often I have to go to the mill to get my entire class.”²⁰⁶

Eyewitnesses who monitored the progress of the Midwife Clubs vouched for the development of the associates and their work. Conferences had good attendance records and became very professional. Midwives incorporated the teaching they received in these conferences into their work. Younger African American women joined the movement, and the rate of literacy increased significantly from the implementation of the club movement in 1921-1922.²⁰⁷

A survey from the 1950s discovered that the most important factor behind the state's elevated maternal death rate was due to a lack of prenatal care. Midwives proved

²⁰⁴ Cox, 2009.

²⁰⁵ Smith, 36.

²⁰⁶ Ibid., 36.

²⁰⁷ Ferguson, 89.

successful in convincing women to go to the health departments and private physicians for this care. Often, rural women did not know of the importance or even the existence of prenatal care. A midwife was responsible for knowing who was expecting a child in her nearby community and getting those women to contact the local clinics. “This is enforced in some counties by forbidding the midwife, on the penalty of losing her permit, to attend a woman in labor unless the woman has procured a slip from” the local health department or a private physician “stating that she has been examined, has had her blood tested, and has been judged a person who can, with reasonable safety, be attended by a midwife.”²⁰⁸

An essential element of a midwife’s responsibility became reporting unregistered cases. A public health nurse made a home visit when an expectant mother did not contact the local health clinic. The nurse explained to the pregnant woman the significance of coming to the clinic, having an examination, going to the maternity instruction classes, and returning for regular appointments. As this dialogue was taking place, the nurse weighed the patient on a moveable scale, took her blood pressure, did a urinalysis, and collected a blood sample. More often than not, the expectant woman arrived on the next clinic day.²⁰⁹

A number of midwives lived in such backwoods regions that it was several years before the reports of the alteration of requirements reached them. The Nursing Division gave an account of the difficulties of licensing one midwife, Minerva P. A midwife club leader reported Minerva to the state supervisor because she was working without a

²⁰⁸ Ibid., 89.

license. After numerous inquiries, the public health nurse found that the plantation on which Minerva resided was an island because of high water. Then, the public health nurse wrote Minerva to come to the health center on Saturday. On April 4, 1939, the following Friday, Minerva left home riding a mule at 4:30 A.M. with her utensils firmly secured in an oilcloth bag fixed to a crocus sack that functioned as a saddle. Throughout most of the day, Minerva traveled through water; near sunset, she had to traverse a flooded stream. Minerva fell into the water after her mule became confused and stumbled. Her brother, who lived nearby, saved her. The following day she hired a car to take her twenty-one miles to the health center. At the health center, the nurse learned that the closest doctor to Minerva was thirty miles away in one direction and fifty in the other, and through water for the majority of the route. Even when the water was down, no other midwife lived within ten miles. Minerva had been oblivious of the new regulations proposed by the State Board of Health or of training given by the public health nurse, and she was engaged to attend four expectant mothers. The nurse took blood for the Wasserman test after the conclusion of the story. This test came back positive on April 5, 1939.

“By May 5, 1939, Minerva was under treatment by a private physician. When the water went down and the nurse was able to visit the plantation, Minerva had a large group assembled. There were several pregnant women to receive instruction, many were protected against smallpox and typhoid fever and infants and preschool children were protected against diphtheria.”²¹⁰

²⁰⁹ Ibid., 89-90.

²¹⁰ Ibid., 88.

Minerva, on April 24, 1940, arrived at the district meeting to have her license renewed. Upon inspection, her equipment was complete and sterilized, and throughout the past year she had been given medicine consistently.²¹¹

Anne Lettieri believes that her mother never attended midwife training sessions because of her isolated living conditions. Even more stunning is the fact that her mother, Mary Williams, delivered nine of her own children. “She didn’t have any choice. She was so far out there was nobody to help her. I always figured that’s why she became a midwife. I guess she figured if she could deliver her own babies she could deliver other people’s too.”²¹²

Midwives were cautious to follow state regulations concerning registration for certification and guidelines of midwife practice. They considered the matter of registration an extremely important one, distinguishing themselves in letters by their permit numbers, as requested by the state. Midwives were careful since the state threatened to invalidate the permits of women who did not abide by the guidelines. In 1923, Mississippi Nurse Mea Reeves revealed that some nurses discovered one midwife treating gynecological cases and children. The midwife’s permit was revoked. In 1924, a nurse in Washington County conveyed: “In follow up work for midwives found that one had delivered case without cap and gown and had also made (digital) examination. Her permit was revoked for one month and at the end of that month she is not to take a case unless I can be with her at time of delivery.”²¹³ Chastisement could be immediate for conducting digital examinations and failing to wear regulation attire. When one nurse

²¹¹ Ibid., 88.

²¹² Ibid., 88.

invalidated the license of a midwife at a convention for the reauthorization of permits, the nurse stated that it “was so upsetting to the midwife that long wailing sobs penetrated the air. The sympathy of the other seventy five midwives brought on more sobbing—needless to say I wondered just what I’d do to restore order and continue with the meeting.”²¹⁴

In severe situations, health departments would summon law enforcement to coerce obedience to the regulations. Nurse Josie Strum, in 1931, as a forewarning to all midwives, decided that she would deal with one midwife with particularly harsh actions. In her description, Strum suggested that “Another midwife was discovered practicing midwifery without a permit, warnings did not seem to do any good so we had her arrested. She was convicted and fined. Now she is very anxious for a permit as well as several others in that same neighborhood.”²¹⁵ Mississippi in later years even used its rigid authority to chastise midwives who supported the civil rights movement. A former midwife residing in Greenville in the 1960s asserted that she had her permit revoked because she “demonstrated and sat in down at Jackson.”²¹⁶

Listen To Me Good: The Life Story of an Alabama Midwife by Margaret Charles Smith and Linda Janet Holmes, published in 1996, is the biography of Margaret Charles Smith. When this work was published, Smith, born in 1906 in Greene County, Alabama, was believed to be the oldest living midwife in the state of Alabama.²¹⁷ Green County, which covers approximately 637 miles, is about 12 miles from the Mississippi state line.

²¹³ Smith, 36.

²¹⁴ Ibid., 36.

²¹⁵ Ibid., 37.

²¹⁶ Ibid., 37.

In 1990, the United States Census reported that Greene County's population was 10,153 persons, with an African American population totaling 8,181.²¹⁸

In the late 1940s, after years of assisting at births of relatives and neighbors, Smith became one of Green County's official midwives. After training and registering with community doctors, she obtained a permit to practice. "Unlike the other dozen or so practicing midwives with permits who never became a part of the public health team in Green County, Mrs. Smith worked regularly in public health prenatal clinics."²¹⁹

According to Smith, the Green County Health Department provided a month-long Saturday instruction program for new midwife recruits. In addition, the midwives attended the lay-midwife program held at Tuskegee. "At Tuskegee, lay midwives gained clinical experience in the maternity unit of Andrew Memorial Hospital, where rural women with medical complications received care at a cost of ten dollars for a ten-day stay."²²⁰

Smith talked candidly about her years of employment under whites prior to the Civil Rights Movement. She remembers how the Civil Rights Era brought about some changes for midwives. In the past, Smith secretly delivered the baby of an interracial couple because they were frightened about the reaction a white doctor might have. She said the Civil Rights Movement helped to quell some of the fear. If Smith assisted white women, more often than not she asked a white doctor to sign the birth certificate.²²¹

²¹⁷Margaret Charles Smith and Linda Janet Holmes, *Listen To Me Good: The Life Story of an Alabama Midwife*. (Columbus: Ohio State University Press, 1996), 2.

²¹⁸ Ibid., 9.

²¹⁹ Ibid., 67.

²²⁰ Ibid., 68.

²²¹ Ibid., 68.

Until there were more hospitals and more physicians, it appeared that the state's only method of improving the circumstances was regulating midwives, necessitating a permit to practice.²²² The Mississippi State Board of Health contended that teaching midwives reduced death rates. For instance, Dr. Felix J. Underwood, the executive officer of the Mississippi State Board of Health from 1924 to 1958, pointed to the drop in state mortality rates following the training of midwives. "The total maternal mortality rates for the state dropped from 9.5 per 1,000 deliveries in 1921 to 4.4 in 1942, with black rates dropping from 12 in 1921 to 5.5 in 1942."²²³ Infant mortality rates, "which are the number of deaths per 1,000 live births in the first year of life," demonstrated a similar pattern.²²⁴ These percentages decreased from sixty-eight percent in 1921 to forty-seven percent in 1942 for the entire state, and from eighty-five to fifty-four for African American babies in the corresponding years. A survey in progress in 1950 discovered that of thirty consecutive maternal deaths in Mississippi, none of them could hold a midwife accountable for neglect.²²⁵ This, however, may have been related to other issues such as upgraded sanitation.

²²² Ferguson, 85.

²²³ Smith, 33.

²²⁴ Ibid., 33.

²²⁵ Ibid., 33.

IV: HILL-BURTON ACT AND THE DEMISE OF MIDWIFERY

In 1946, Congress enacted the Hospital Survey and Construction Act, otherwise known as the Hill-Burton Act. This piece of legislation reacted to the first of President Harry Truman's proposals and was intended to supply federal grants and guaranteed loans to build up the country's hospital system. Funds were assigned to the states to realize "4.5 beds per 1,000 people."²²⁶

Facilities that obtained subsidies from Hill-Burton had to consent to numerous requirements. They were not permitted to "discriminate based on race, color, national origin or creed—except for the proviso that allowed for discrimination so long as separate, equal facilities were located in the same area."²²⁷ In 1963, the Supreme Court prohibited this separation. "Facilities that received funding were also required to provide a 'reasonable volume' of free care each year for those residents in the facility's area who needed care but could not afford to pay."²²⁸ According to Lester Lave and Judith Lave, authors of *The Hospital Construction Act; An Evaluation of the Hill-Burton Program, 1948-1973*, the decree that exemplified the Hill-Burton program granted that funding be provided to the states for two functions: to help with an appraisal of state requirements

²²⁶ U.S Department of Health, Education, and Welfare, "Hill-Burton Program Progress Report July 1, 1947-June 30," 1967 (Washington, D.C.: Public Health Service Publication, 1967), iii-8.

²²⁷ Smith, 37.

²²⁸ Ibid., 37.

and to flesh out state strategies for the building of community and other charitable hospitals and municipal health centers; and to support the construction of such structures.²²⁹

When the 79th Congress passed The National Hospital Survey and Construction Act, Mississippi quickly took advantage of the federal assistance it provided. The 1946 regular session of the Mississippi Legislature established its own Commission on Hospital Care under the national act and appropriated \$5,000,000.00 for the first two years of the long-range program. The 1948 legislature increased this assistance to a total of \$10,000,000.00 accessible as the state's portion. The Commission on Hospital Care rapidly organized a workforce and began the widespread review of existing hospital facilities required under the national act.²³⁰

In 1946 there were only 114 hospitals with 4200 beds to serve Mississippi's 2,180,796 persons, or an average of only 1.6 beds per 1000 persons. "Thirty-seven of these facilities had less than 16 beds each. The 114 hospitals were not strategically located, leaving 24 counties with a population of 425,000 with no hospital facilities whatever."²³¹ With this information, the Commission launched a plan that would supply four and one-half beds per 1000 persons in compliance with standards established by the Surgeon General, which is 4.5 beds per 1000 population for urban areas, and 2.5 beds for rural areas. In addition, the Commission suggested a well-integrated arrangement of

²²⁹ Lester Lave and Judith Lave, *The Hospital Construction Act; An Evaluation of the Hill-Burton Program, 1948-1973* (American Enterprise Institute for Public Policy Research, 1974), 5.

²³⁰ *Mississippi Commission on Hospital Care*. "New Hospitals and Health Departments for Mississippi." D. V. Galloway M.D., Executive Director, 5.

²³¹ *Ibid.*, 5.

local hospitals, clinics, and Health Departments that would place hospitals or clinical amenities within 15 miles of 90 percent of the population.²³²

From 1946 to 1965, the national government identified success by ratios of beds to population. Describing the need of hospital treatment by these provisions brought about intense disapproval. Opponents contended that the figure was subjective and that the need for a treatment facility might be completely different in regions with the same size population, “so that a given bed-population ratio could mean excess capacity in some regions and crowding in others.”²³³ Even though urban facilities were frequently outdated, a municipality with “enough” beds could not obtain aid from the Hill-Burton program for needed restoration.²³⁴

For inpatient hospitals criterion became more advanced. The Public Health Service method for establishing need, instituted in 1965, consisted of three critical standards: “population (projected for five years); current utilization rates (the number of bed-days actually used by the population); and an occupancy factor (the average percentage of beds maintained for patient care that are filled).”²³⁵ For outpatient hospital beds this average is 80 percent; for long-term care facilities, 90 percent.²³⁶

Surveyors discovered that many Mississippi hospitals were “crowded beyond a condition of efficient operation.”²³⁷ Due to overcrowding, there were numerous instances where patients were placed in sun parlors, in hallways, and in other areas of the hospital

²³² Ibid., 6.

²³³ Lave, 8.

²³⁴ Ibid., 8.

²³⁵ Ibid., 9.

²³⁶ Ibid., 9.

²³⁷ D. V. Galloway, M.D., “First Biennial Annual Report of the Commission on Hospital Care of the State of Mississippi.” Jackson, Mississippi, July 1, 1946-June 30, 1947, 1.

not intended for patients. This overcapacity and disarrangement made it a challenge for hospitals to provide patients with proper treatment.²³⁸

The people of Mississippi were deeply interested in the development of the hospital services to meet the state's pressing need for adequate facilities. To help local communities, the Commission prepared a guidebook delineating the process for deciding the hospital needs of the local communities, and report blanks were provided whereupon surveyors could convey to the Commission their conclusions and their plans as to the expansion of the community hospital programs. "The information, facts, and material furnished by these committees has been of inestimable value in setting up the overall hospital plan—in fact, the people of the state have largely made their own hospital plan."²³⁹

On July 1, 1947, the Surgeon General approved the state agenda, and Mississippi was the first state to obtain permission to carry on with its hospital construction plan. Local communities raised more than \$6,600,000.00 as their part of the investment. "The overall program was supported on a three-way basis: federal 66-2/3%, state 20%, and local 15%."²⁴⁰

A survey made in 1950-1951 shows a total of 151 hospitals having an operational bed capacity of 5573. "Of these beds, 3872 were for white and 1789 for African American patients. Eleven counties were without hospital facilities within their borders."²⁴¹ Of these eleven counties, three joined with neighboring counties in the

²³⁸ Ibid., 1.

²³⁹ Ibid., 3.

²⁴⁰ *Mississippi Commission on Hospital Care*, 6.

²⁴¹ Foster L. Fowler, "Third Biennial Report Covering the Fourth and Fifth Years of the Mississippi Commission on Hospital Care." Jackson, Mississippi, July 1, 1949-June 30, 1951, 7.

support of a hospital actually located in the neighboring county but serving both. In 1950, two other counties had applications pending and anticipated beginning construction when federal resources for the project became accessible. A sixth county indicated an active interest in completing an application to build a hospital and the surveyors expected that to be done as soon as it could obtain federal funds. The remaining five counties were all adjacent to one or more counties that had new hospital facilities either completed or currently under construction.²⁴²

As statistics from the hospital survey and the study of community needs began to accumulate, it became apparent that in Mississippi a minimum of 100,000 people were required to fund the construction and operation of hospital amenities sufficient to provide up to date medical care. Contemplating the physical geography and trade areas of the state, and the highway and transportation systems, in addition to the centers of population, Mississippi was separated into 17 hospital regions, each region to develop a collection of hospitals around a central or regional base hospital. All of these regional or base hospitals were a hospital of more than 100 beds, and each would be qualified to set up a “standard nursing school, standard internship, and other vital medical education programs.”²⁴³

In the development of the hospital plan, the Commission not only considered the necessary operating room capacity, bed capacity, and laboratory and scientific amenities for diagnosis and treatment of hospital patients, but it was also intended as a basis for Mississippi’s medical education curriculum. “The shortage of doctors, nurses, laboratory workers, dietitians, and other skilled hospital personnel is so acute that the success of the

²⁴² Ibid., 7.

hospital program depended to a large extent upon securing adequate staff to keep the hospitals in operation.”²⁴⁴ Actually, a number of the state’s hospitals were unable to operate to their complete capacity due to a lack of nursing and other qualified employees.²⁴⁵

The completion of new hospitals brought new problems, but not unforeseen problems. “Recognizing the need that then existed and anticipating a greater shortage in the future the legislature by enactment of Chapter 436, Laws of 1946, provided for aid to students of medicine in return for which they were to obligate themselves,” upon graduation, to practice medicine within Mississippi.²⁴⁶ It supplied loans to “deserving young future physicians in the amount not to exceed \$5,000.00 over a period of four years, or not to exceed \$1,250.00 in any one school year.”²⁴⁷ The terms of the agreement stated that young physicians must promise to return to a rural community or area of 5,000 or less population and practice. Beginning on January 1, 1950, such loans had been granted to 228 Mississippians, and these young doctors agreed that they would return to practice during a period of six to seven years. This number increased with each graduation. The construction of the new four-year medical school and teaching hospital greatly accelerated this movement in addition to providing facilities for specialized medical services not available or practical in the smaller community hospitals.²⁴⁸

In 1950, nine young doctors had already gone into practice in rural regions. “Over 20 were serving internships, over 175 were enrolled in 23 different medical

²⁴³ Galloway, 3.

²⁴⁴ Galloway, 3.

²⁴⁵ Galloway, 3.

²⁴⁶ Fowler, 7.

²⁴⁷ Ibid., 7.

schools throughout the United States, and six medical schools accepted first-year medical students from Mississippi through this program.”²⁴⁹ Surveys in 1950 proved that fifty percent of all Mississippians studying medicine in that same year, either inside or outside the state, had entered or were completing medical training by way of the state medical education loan plan.²⁵⁰

To diminish the nurse shortage in Mississippi and to assist in supplying adequate nursing staff for future hospitals, with the beginning of the fall session of 1948 the state instituted a department of nursing at the University of Mississippi. The new department presented high school graduates the opportunity to complete a four and a half year core curriculum that led to a Bachelor of Science degree in nursing. In addition, the new department had the duty of helping established organizations in improving nursing education, therefore upgrading and increasing nursing services. Numerous programs operated on a statewide basis to achieve this agenda. These programs were the outcome of joint efforts of the Department at the University of Mississippi, the Mississippi State Nurses’ Association, the Mississippi Commission on Hospital Care, the Mississippi State Board of Nurse Examiners, the Mississippi State Hospital Association, the Mississippi State League of Nursing Education, and the Mississippi State Board of Health. These programs included instituting in-service curricular in each hospital for on-the-job training of nursing staff and obtaining and providing skilled instructors to hospital schools throughout the state. These services were accessible on a revolving basis of two or three months in each hospital school, and imparted direction to community groups in merging

²⁴⁸ Ibid., 7.

²⁴⁹ *Mississippi Commission on Hospital Care*. 10.

²⁵⁰ Fowler 7.

the nursing instruction of two or more hospital educational programs into a central instructional unit.²⁵¹

To supply skilled instructors for this and other nursing schools in Mississippi, “the 1948 Legislature also established a program of state assisted graduate nursing scholarships, the first of its kind in the United States.”²⁵² Scholarships up to \$3,000 were granted to deserving graduate nurses for advanced study in colleges and universities offering advanced nursing education programs. In return, they promised to come back to Mississippi for a minimum of one year for each of their scholarship. An appropriation of \$85,000.00 provided scholarships for these students. As of January 1, 1950, such scholarships had been granted to 33 graduate nurses. Student nurse enrollment in the state increased from about 475 in 20 schools of nursing in 1947 to about 825 in 19 schools of nursing in 1951.²⁵³

To place hospitalization within the reach of all levels of the population, the 1946 Legislature set up a commission of six persons whose duties would consist of endorsement of a “voluntary nonprofit hospitalization program in Mississippi.”²⁵⁴ The Blue Cross Plan, a voluntary prepayment plan for hospital and surgical bills, was instituted under the Mississippi and Medical Service Association in Jackson. Hospital commission administrators thought subscription to this inexpensive type of insurance would make use of the future new hospitals accessible to even the lowest income group in the state. The same local leaders and civic clubs who endorsed the hospital construction ventures also endorsed Blue Cross. “As of January 1, 1950, Blue Cross

²⁵¹ Ibid., 7-8.

²⁵² Ibid., 11.

²⁵³ Ibid., 11.

Insurance contracts had been issued to 25,000 families covering 60,000 individuals.”²⁵⁵

All of the major hospitals in the state were associated with the Mississippi Medical Service Association and consequently, Blue Cross members obtained over \$500,000.00 in benefits.²⁵⁶

On March 24, 1954, the Mississippi Commission on Hospital Care adopted minimum standards of operation for licensing hospitals within the state. It is interesting to note that for a number of years midwives had been observing many of the same requirements that hospitals were being forced to adopt as late as the 1950s. However, the predominately African American midwives were not given the opportunity to use their training as nurses in the state’s hospitals. The Commission required maternity and newborn services to be located and arranged to provide for maximum protection of mothers and newborn infants from infection and from cross-infection from patients in other sections of the hospital.²⁵⁷ Obstetric and newborn amenities were to be under the management of a member of the staff of physicians who was suitably selected for that task. The Commission required there to be a capable professional registered nurse accountable continually for the nursing care of maternity patients and newborn infants. Much in the same way that midwives were expected to undergo routine health screenings, the Commission also necessitated that requirements be made for all pre-employment and annual health examinations for all employees who came into contact with maternity patients and newborns.

²⁵⁴ *Mississippi Commission on Hospital Care*. 12.

²⁵⁵ *Ibid.*, 12.

²⁵⁶ *Ibid.*, 12.

²⁵⁷ *Mississippi Commission on Hospital Care*, “Minimum Standards of Operation for Mississippi Hospitals.” (Jackson, Mississippi: Mississippi Department of Archives and History), July 1, 1966, 16.

Concerning the maternity ward, the Commission required for there to be provisions and guidelines regarding the treatment of patients with infectious, contagious, or communicable diseases which would insure the protection of other maternity patients and newborn infants. A mother should be deemed infected and should be isolated if: she had nursed an infected infant, had a communicable illness or was a carrier, was delivered outside the maternity ward of the hospital in which she was subsequently treated, or had an unexplained fever throughout the puerperium.²⁵⁸ Another similarity between hospital care and the care that midwives gave their patients is that hospitals were required to keep a chart for each maternity patient and a separate chart for each newborn infant. Like midwives, hospitals kept delivery room records which would indicate the name of the patient, her maiden name, date of delivery, sex of infant, name of physician, name of persons assisting, what complication, if any, occurred, type of anesthesia used, and name of person administering the anesthesia.²⁵⁹ Even though African American midwives had already acquired similar medical training due to state regulations, these women were not given the opportunity to continue their healthcare work within Mississippi's hospitals.

According to information gathered by the Business Research Station, the hospital situation in Mississippi improved significantly from 1945 to 1953. In 1945, twenty-nine of Mississippi's eighty-two counties were without hospital facilities. In 1953 there were only eleven counties that lacked hospitals. "The number of hospital beds increased from 4,426 in 1945 to 6,053 in 1953. Likewise the population per hospital bed dropped from

²⁵⁸ Ibid., 18.

²⁵⁹ Ibid., 19.

an average of 494 in 1945 to 360 in 1953.”²⁶⁰ Twenty-two out of the state’s eighty-two counties had at least one hospital bed for each 300 white people in 1945. “By 1953 there were thirty-three counties with at least one hospital bed for each 300 white people. Between 1945 and 1953 there was a 50 percent increase in the number of counties having one bed for each 300 of white population.”²⁶¹ In 1953 there were only four counties in the state that met the ratio of one hospital bed for each 300 of the African American population, and in 1953 this ratio had increased to eight counties. Therefore, between 1945 and 1953 there was a 100 percent increase in the number of counties showing this ratio. “Even so, the hospital facility situation, in so far as the colored population was concerned, remained critical in most counties and in some cities in 1953.”²⁶²

An additional improvement in the allocation of hospital facilities was indicated by the fact that only two counties with hospital facilities supplied no provision for African American patients in 1953. In 1945 there were five counties where the hospitals provided no beds for African Americans. It is noteworthy that in Tishomingo County, one of the two counties that reported no beds for African American patients in 1953, 95 percent of the population was white. In Hancock, the other county with no beds for African American patients, 83 percent of the population was white.²⁶³ However, the statistics on hospital beds for each one thousand of white and each one thousand of black, the ratio for the African American population was far below the national average in both 1945 and 1953. “It was 1.31 beds for each one thousand colored persons in 1945 and

²⁶⁰ John J. MacAllister, “Hospital Facilities In Mississippi.” (Jackson, Mississippi: Mississippi Department of Archives and History), Business Research Station Special Study Series Bulletin Number Eight, 1953, 5.

²⁶¹ Ibid., 6.

²⁶² Ibid., 12.

²⁶³ Ibid., 12.

1.83 per each one thousand in 1953.”²⁶⁴ In contrast, the numbers for the white population were reasonably acceptable in both 1945 and 1953. In 1945 there were 2.86 hospital beds for each one thousand white persons, whereas in 1953 there were 3.59 hospital beds for each one thousand white persons. “Thus, in 1953 Mississippi’s white population lacked 0.7 of one hospital bed of being within the national standard. On the other hand, Mississippi lacked 1.5 hospital beds of meeting the national standard for 4.3 for total population.”²⁶⁵

From 1946 until 1973 the monetary conditions for charitable hospitals experienced significant transformation. Charitable contributions ceased to be the primary source of funds for building construction and operating cost. Third party funding of hospital care, such as Blue Cross, Medicare, and Medicaid, had developed into the main source of hospital earnings, and hospitals had become extremely costly, in terms of both buildings and costs of operation. No matter what the ambitions were for the 1946 Hill-Burton program, different requirements came to the forefront in 1974 when Judith and Lester Lave directed their report. Undeniably, the Hill-Burton program’s accomplishment’s in erecting medical facilities has been a factor in these modifications.²⁶⁶

The act initially passed was amended frequently. For example, in 1954, a modification to the act presented the states with funding to help exclusively in the creation of outpatient centers, hospitals for the terminally ill, and treatment facilities. In 1964, amendments supplied resources for the modernization of facilities. “In 1970 the

²⁶⁴ Ibid., 14-17.

²⁶⁵ Ibid., 17.

²⁶⁶ Lave, 5.

grant programs were supplemented by a loan guarantee program, under which, in lieu of a construction grant, the federal government pays a portion of the interest cost and acts as co-signer of loans to selected hospitals, guaranteeing the payment of principal and interest.”²⁶⁷ In addition, the secretary of health, education, and welfare is capable of providing credit to assist municipal organizations in completing their plans for construction and upgrading of health centers.²⁶⁸

According to the Laves’ report, Hill-Burton’s accomplishment in making funds available for construction and upgrading is apparent. “By June 30, 1971, 10,748 projects had been approved, about one-third for new facilities and the balance for modernization, such as additions, alterations, and replacements to existing facilities. The total cost was \$12.8 billion, of which the federal government provided \$3.7 billion.”²⁶⁹ According to Lester and Judith Lave, whether short-term acute, or general, hospitals obtained the principal portion of Hill-Burton financial assistance.²⁷⁰ In spite of this, by 1971 short-term hospitals were no longer the main focus for Hill-Burton funds. “In fiscal year 1971, only 55 percent of the funds went toward the construction and modernization of short-term hospitals, in contrast with the 71 percent average in prior years.”²⁷¹

The fact that Hill-Burton granted a portion of the assistance for almost \$13 billion in hospital construction between 1948 and 1971 is not significant without some assessment of total expenses related to the construction of health facilities. From 1949 to 1962, approximately “30 percent of all hospital construction projects were assisted, on

²⁶⁷ Ibid., 8.

²⁶⁸ Ibid., 8.

²⁶⁹ Ibid., 13.

²⁷⁰ Ibid., 13.

²⁷¹ Ibid., 16.

average, under the program; to put it another way, about 10 percent of the annual cost of all hospital construction over this period was paid directly by the federal government under the Hill-Burton program.”²⁷² For example, in 1962, 13.9 percent of the total expenditure of the construction of health facilities and 38.6 percent of the expenditure of construction of hospitals in receipt of some program assistance was funded by Hill-Burton endowments. Consequently, the Hill-Burton program funded a small but noteworthy percentage of hospital construction.²⁷³

The initial decree demanded the state Hill-Burton bureau to give precedence to rural and low-income regions when distributing financial support. The rural precedence was not included in new programs, such as that for reconstruction, and was abandoned after 1970. Therefore, one would suppose that projects sponsored by the Hill-Burton program would have a tendency to be focused in low-income and rural districts, but to a lesser degree in recent years.²⁷⁴

The authors found that in recent years the overall history of Hill-Burton has not fluctuated drastically “Funds continued to be concentrated in cities of 10,000 to 25,000. Over the course of the program these cities accounted for 19.8 percent of total projects and 22.0 percent of total funds.”²⁷⁵ The amount of assistance obtained by these cities diminished in the late sixties. “Between 1968 and 1970 they undertook 15.2 percent of the beds constructed with Hill-Burton support, and received 17.3 percent of the funds.

²⁷² Ibid., 16.

²⁷³ Ibid., 16.

²⁷⁴ Ibid., 19.

²⁷⁵ Ibid., 19.

These numbers can be put in perspective by noting that in 1960, 9.8 percent of the population resided in communities of that size.”²⁷⁶

The concentration of Hill-Burton on smaller areas is verified by the fact that 74.8 percent of all short-term hospital ventures under the plan were implemented in areas with a population of less than 50,000. “They received 67.2 percent of total funds. Since 63.8 percent of the population lived in these communities, the program transferred more funds per capita to the residents of smaller communities.”²⁷⁷ Between 1968 and 1970, governmental awareness transferred to the low-income districts in large cities. Nevertheless, the most heavily populated cities profited from only a minor escalation in projects and resources.²⁷⁸

An analysis of Hill-Burtons’ reallocation effect can be acquired by contrasting these statistics with the 1960 distribution of population. “Each category of city between 2,500 and 249,999 population received a share of funds greater than its proportion of population.”²⁷⁹ Each obtained a larger sum of Hill-Burton resources per capita than regions above or below this range. “Cities of 2,500 to 25,000 received about 150 percent more funds per capita than a proportional allocation would have called for, and the next three categories of cities (up to 250,000) together benefited 60 percent more than population alone would have called for.”²⁸⁰ According to the authors findings, “cities of less than 2,500 (and rural areas) received 77 percent less funds per capita, and cities of more than 250,000 received 39 percent less than sheer numbers suggested they were

²⁷⁶ Ibid., 19.

²⁷⁷ Ibid., 19.

²⁷⁸ Ibid., 19.

²⁷⁹ Ibid., 21.

²⁸⁰ Ibid., 21.

entitled to.”²⁸¹ The seemingly imbalanced quantity obtained by smaller municipalities exaggerates the transfer effect because they also aided the rural inhabitants.²⁸²

A 1960 report illustrates the allocation of Hill-Burton resources to the 1960 median family earnings of the county where the hospital is located. It proves that 13 percent of the ventures sponsored were attempted in counties where the 1960 average family earnings were less than \$3,000. Even though an exceptionally high percentage of construction expenditures of hospitals in low-income communities were funded by the federal endowment, they acquired a lesser amount of the resources. The largest percentage of Hill-Burton funds went to short-term hospitals in middleclass neighborhoods.²⁸³

The distribution of the financial resources provided by the Hill-Burton program has been compliant with the intent of the law. Nevertheless, to assess the policy, the Laves ventured further than a straightforward investigation of money flow to uncover whether the program was successful in accomplishing its objective. The aim of the policy in 1946 can be divided into two components: “(1) to increase the supply of hospital beds and improve the distribution of medical services, and (2) to rationalize the planning of physical facilities with respect to their location and coordination.”²⁸⁴

At the 1940 and 1945 inquiry before the subcommittee of the Senate Committee on Education and Labor on the initial Hospital Survey and Construction Act, emphasis was placed on the overall scarcity of hospital services, even though estimates of its degree varied. In accordance with the law, Hill-Burton organizations were to perform a

²⁸¹ Ibid., 21.

²⁸² Ibid., 21.

²⁸³ Ibid., 21.

survey of hospital facilities, decide which beds were “conforming,” and calculate approximately how many extra beds were required. These approximations were to develop the groundwork for Hill-Burton’s policy.²⁸⁵

According to information documented by HEW, in 1948 there were 469,398 short-term hospital beds, 83 percent of which were in compliance with Hill-Burton regulations. The state programs projected that approximately 56 percent more beds were required. “In 1969 there were 826,711 beds, 40 percent of which had been partially supported by Hill-Burton funds; 70 percent were considered to be conforming, and about 11 percent more beds were needed, many because of shifts in the geographical distribution of the population.”²⁸⁶ Statistics on the majority of other categories of facilities supported by Hill-Burton are less significant because the standards are subjective. The exception, however, is long-term facilities. “In 1957, there were 267,356 long-term beds; 58 percent were considered to be conforming and an estimated 28 percent more were needed.”²⁸⁷ There were 772,164 long-term beds in 1969, 12 percent of which were constructed with some Hill-Burton funding. Of these, 65 percent were deemed to be conforming; approximately 22 percent more were considered necessary. These numbers apply to beds in skilled nursing homes, where the greatest portion of the increase during this period occurred, to long-term and chronic-care facilities, and to long-term units in hospitals.²⁸⁸

²⁸⁴ Ibid., 25.

²⁸⁵ Ibid., 25.

²⁸⁶ Ibid., 25-26.

²⁸⁷ Ibid., 26.

²⁸⁸ Ibid., 26.

According to Hill-Burton statistics, the overall scarcity of hospital beds has, for the most part, been eliminated. Consequently, one of the objectives of the program was met. According to the Laves the program might have been too successful. “The 1973 Hill-Burton definition of need is based on current bed use, target rates for hospital occupancy, and projected population growth. To the extent that current bed use is inappropriate, Hill-Burton estimates of need will be incorrect.”²⁸⁹

In many instances hospitals built with Hill-Burton funds often ignored government regulations. According to Margaret Charles Smith, in 1966, Green County opened its first community hospital. “Although constructed with federal Hill-Burton funds, this facility continued to practice illegal segregation even after the signs were removed.”²⁹⁰ James Coleman, “the executive director of Greene County’s first comprehensive health clinic, which opened in 1974,” remembers ““going over to the hospital in 1969-1970 and one day there were two waiting rooms. The next day they closed one because an inspector was coming, but nothing really changed.””²⁹¹

According to historian Karen Kruse Thomas, “Hill-Burton helped to reduce the large number of non-hospital births without a physician, particularly among rural blacks, that contributed to high southern rates of maternal and infant mortality.”²⁹² However, Thomas concludes that the increase of African American babies being born in hospitals “did not result in an overall reduction in southern black infant mortality rates.”²⁹³ Thomas sees Hill-Burton as a civil rights achievement for African Americans. Yet, she

²⁸⁹ Ibid., 26.

²⁹⁰ Ibid., 115.

²⁹¹ Ibid., 115.

²⁹² Karen Kruse Thomas, “The Hill-Burton Act and Civil Rights: Expanding Hospital Care for Black Southerners, 1939-1960.” *The Journal of Southern History*. Volume LXXII (November 2006): No. 4, 847.

²⁹³ Ibid., 847.

ignores the adverse affects of this legislation, which deprived African American midwives of their practice and often their primary means of financial support. According to Ms. Sarah Ruth Pratt, an African American woman who resides in Union County, Mississippi, a well-known midwife often referred to as Aunt Hattie “made her living by picking cotton and delivering those babies. As far as the black community, they (midwives) were considered middle class because they had a little something. She (Aunt Hattie) had a profession instead of just going to the fields.”²⁹⁴ In Mississippi, where the minimum wage was \$.75 per hour in 1950 and midwives often collected as high as \$25.00 per delivery,²⁹⁵ Ms. Pratt believes that midwives were forced into retirement because “they (midwives) had a lot of business and it was kinda stepping on the doctors’ business because by this time blacks had a little insurance and could pay.”²⁹⁶ Dr. John Patterson from Pontotoc, Mississippi, whose practice spanned from 1955 to 2003, agrees with Pratt’s assessment. According to Patterson, who delivered approximately 2,000 babies throughout his career, the Pontotoc hospital was built with Hill-Burton funds. He believes that women being able to receive free care at Hill-Burton hospitals “was the one biggest factors” in phasing out the midwives.²⁹⁷ “If you can go to a hospital and get first-class service for free, why would you want to pay a midwife?”²⁹⁸

Even though many nurses remarked in their reports on the indispensable public health work achieved by lay midwives, the certified procedure of the board of health

²⁹⁴ Sam Mosley and Sarah Ruth Pratt, interview by L. Lane Noel, October 17, 2009, New Albany, Mississippi, tape recording.

²⁹⁵ University of Virginia Historical Census Browser. Available online, accessed November 23, 2009. <http://fisher.lib.virginia.edu/collections/stats/histcensus>.

²⁹⁶ Mosley and Pratt, October 2009.

²⁹⁷ Dr. John Patterson, interview by L. Lane Noel, November 3, 2010, Pontotoc, Mississippi.

²⁹⁸ Patterson, 2010.

eventually eradicated midwives. In an attempt to hasten the removal of midwives, Nurse Supervisor Lucy E. Massey in 1948 introduced a retirement program initially recommended by her district nurses. The arrangement fervently promoted the retirement of elderly midwives by notifying them and their relatives that they were too old to renew their licenses and then honoring them with ceremonies.²⁹⁹ “In getting a midwife to retire it is frequently a good idea to talk with her children and her pastor and enlist their aid in convincing her that she should ‘step down.’”³⁰⁰

It was encouraged that these “occasions be marked by as much ceremony as possible so that the retirement would be taken more seriously.”³⁰¹ A retirement badge was prepared to hasten the retirement of midwives who were perceived as too old to practice. No similar efforts, of course, were made with physicians. Any midwife who obtained this badge was known as a Mary D. Osborne Retired Midwife. Mary D. Osborne was the midwife program director in Mississippi in the 1930s and 1940s. When she obtained this badge, the midwife was required to return her permit and pledge that she would no longer practice.³⁰² A retired midwife proudly wore her retirement badge to community gatherings and to church for the rest of her life.³⁰³

Although the retirement services almost certainly never deceived the midwives forced into giving up their practice, they did present an occasion for the nurses and members of the area to honor the retiring women. The public health nurse ordinarily held the occasion at a neighborhood church where the midwife “would sit queen for the

²⁹⁹ Smith, 40-41.

³⁰⁰ Policies Regarding Midwife Supervision, 4.

³⁰¹ Ibid., 4.

³⁰² Ibid., 4.

day.”³⁰⁴ Frequently people, particularly women whom she had attended, would drop cash in the midwife’s lap. According to a newspaper account of one midwife retirement service, “the aged pair, clad in white uniforms and caps, and clutching small American flags, sat solemnly in pink and white decorated chairs of honor, placed near the altar.”³⁰⁵ The black midwife leader and the white county nurse both presented speeches of admiration for the women. While associates of the community midwife club guided a procession “robed in white uniforms and caps, and also carrying tiny American flags,” individuals attending sang hymns.³⁰⁶ Midwives read Bible verses, sang, offered up prayers, and awarded presents to the retiring women.³⁰⁷

Although Margaret Charles Smith delivered close to three thousand babies, she never lost a mother and seldom lost a baby. However, in 1976 Alabama joined other southern states in adopting laws to terminate the practices of lay midwives. “Mrs. Smith attended her last birth at the age of seventy-five in 1981, five years after the law ended the issuance of new lay-midwife permits and allowed only nurse-midwives³⁰⁸ to be licensed.”³⁰⁹ Between the years of 1976 and 1981, “over 150 African American Alabama midwives lost their permits to practice.”³¹⁰ The termination of lay midwifery ran into an exceptionally challenging power in Smith. Even though the medical establishment took away her practice, Smith continued to have a voice in both the local and national arena. In 1983, “she won honors at the first Black Women’s Health Project Conference in

³⁰³ Ferguson, 90.

³⁰⁴ Smith, 41.

³⁰⁵ Ibid., 41.

³⁰⁶ Ibid., 41.

³⁰⁷ Ibid., 41.

³⁰⁸ Nurse-midwives, registered nurses with credentials from the American College of Nurse-Midwives, usually work in hospital settings.

³⁰⁹ Ibid., 41.

Atlanta, and she later attended the Working Conference to Preserve Traditional Midwife Practices at Spellman College in Atlanta. None of these efforts however could restore Smith's practice."³¹¹ In an uncommon instant of despondency, Smith declared to Holmes, "I never wanted plaques to hang on my wall. I wanted to be a midwife."³¹²

"By the 1980s, little remained of the much maligned institution of black midwifery. After a century of grudging acceptance, Alabama, like other Deep South states, ceased issuing permits to 'granny' midwives. A practice once considered natural became illegal."³¹³ In 1976, the enactment of new legislation overseeing the practice of nurse-midwives led to the demise of traditional midwives. Alvin Holmes, the African American representative who cosponsored the bill, remembers little controversy about its enactment. Even though Act No. 499 explicitly states: "Nothing in this section shall be construed as to prevent lay-midwives, holding valid health department permits, from engaging in the practice of lay-midwifery as heretofore provided until such time as said permit may be revoked by the County Board of Health."³¹⁴ County health departments made it very difficult for lay-midwives to renew their permits. In a number of counties physicians refused to sign midwife permits, which was mandatory under the law to be able to practice. Health departments throughout Alabama hastily "retired" many midwives. For the first time, counties began implementing health department rules necessitating that no midwife over the age of sixty-five be permitted to practice.³¹⁵

³¹⁰ Ibid., 2.

³¹¹ Ibid., 2.

³¹² Ibid., 2.

³¹³ Ibid., 134.

³¹⁴ Ibid., 134.

³¹⁵ Ibid., 134.

“After decades of practice, more than 150 Alabama midwives, all African American, abruptly received letters and visits from physicians and nurses informing them that they could no longer practice. Alabama placed severe strictures on a system that had included twenty-six hundred midwives in 1942.”³¹⁶ According to Smith, “in one instance, a nurse casually dropped by the home of a midwife whose practice in Mobile County had begun in the 1920s, and told her that she was no longer a midwife.”³¹⁷

Dr. Goldenburg, Alabama’s state health department director of maternal and child health, reacted to the mounting alarm concerning the nurse-midwife order for the practices of “granny” midwives on June 12, 1979, by issuing new rules: “ ‘No new granny midwives are to be certified after April 1, 1978.’ This meant that for the first time, women who were descendants of slave midwives could not continue their family tradition.”³¹⁸

The laws abolishing lay midwifery encountered little organized opposition. Traditional midwives, characteristically elderly rural women, had no organization to plead their cause. “After decades of working under the supervision of local health departments, they found that they lacked the political means to develop advocates and allies.”³¹⁹ Midwife clubs backed by county health departments provided training lessons, community events, and even religious services, but they avoided political organizations and approbation matters. Civil rights associations and recently organized rural unions, which tackled many proletariat financial matters, never supported midwives.³²⁰

³¹⁶ Ibid., 135.

³¹⁷ Ibid., 135.

³¹⁸ Ibid., 135.

³¹⁹ Ibid., 135.

³²⁰ Ibid., 135.

“With the passage of Medicaid in 1965, many traditional midwife clients turned to hospital based medical care. A new generation of childbearing women took their place. For them, midwives were associated with old-time ways, poverty, and segregation.”³²¹ The Alabama Department of Health sponsored its last midwife training conference at Montgomery’s Civic Center in 1981. “The midwives in attendance were deeply concerned about their fate, but they had no forum in which to express their fears. Instead they heard how the new rules made their practices more difficult.”³²² They were mocked “for their lack of formal education, heard their skills questioned, and learned of strict enforcement of new regulations.”³²³ For traditional midwives the thought of continuing their practice unlawfully or in secret was not realistic. Challenging the white medical establishment is more dangerous for them than it is for the new cohort of midwives. Traditional midwives are correct to understand their destiny differently from that of their white contemporaries due to the century-long cynicism displayed toward them by the medical structure. “Many of the older black midwives recognized that racial bias in the health care system, as in the criminal justice system, hindered opportunities for blacks.”³²⁴ While a number of white midwives appealed to the court system and consolidated connections “with the political power structure, black midwives expected doors to be shut in their faces.”³²⁵ According to Smith, all the medical establishment “wanted was the midwives off. Training was the last thing they wanted. They wrote me

³²¹ Ibid., 136-137.

³²² Ibid., 140.

³²³ Ibid., 140.

³²⁴ Ibid., 140.

³²⁵ Ibid., 140.

at the health department that I couldn't be no more midwife. I had to bring my bag and my equipment in, not only me, but all of them that was delivering.”³²⁶

The number of Mississippi midwives cataloged by the state started to decline in the post-World War II period partly due to state policy. In addition, movement of African Americans to northern cities and Mississippi towns led to smaller numbers of black midwives residing on plantations. By 1966 midwives in Mississippi, whose numbers had once been in the thousands, numbered a mere six hundred. Nevertheless, they still delivered approximately ten thousand babies that year. By 1982, the state had just thirteen authorized midwives and no longer issued certificates or held teaching conferences³²⁷

In the 1990s, however, childbirth by midwives had achieved a noteworthy following once again on a national level but not in Mississippi. In the United States in 1994, midwives attended 218,466 births; over seven times the number in 1975 (29,413). In 1975, the proportion of all births increased from 0.9 percent to 5.5 percent in 1994. The rising percentage of midwife-attended deliveries is accredited to specialized nurse-midwives (CNMS), whose utilization escalated fifty-five percent from 1989 to 1994. Between 1975 and 1988, approximately ninety-three percent of the rise in midwife-attended births took place in hospitals, and between 1989 and 1994, these in-hospital births were responsible for one hundred percent of the upsurge. Even as out-of-hospital

³²⁶ Ibid., 145.

³²⁷ Ferguson, 90.

attended births dropped, the overall number of in-hospital midwife-attended births rose by fifty seven percent over this six-year interval.³²⁸

In out-of-hospital locations, women who were attended by midwives had “demographic and lifestyle characteristics” that provided a reduced threat for poor birth outcomes and obstetric complications compared with mothers who were attended by a physician or midwife in a hospital.³²⁹ It was more probable that these women were older, married, and had a better educational background. In addition, they were less likely to smoke or gain excessive weight throughout their pregnancies. Yet, women with midwife-attended births, in spite of the type of birth setting or midwife, were more prone to begin prenatal care further along in the pregnancy than were women whose births were attended by medical doctors. “Despite less prenatal care, a smaller portion of children whose births were attended by midwives were preterm or were of low or very low birth weight.”³³⁰

A safe, cost-effective alternative to delivery by doctors for women who have a low chance of obstetric complications is still delivery by midwives. “Midwife-attended births have comparable birth outcomes as those by physicians and are less likely to have obstetric interventions, such as electronic fetal monitoring and epidural analgesia use factors contributing to decreased costs.”³³¹ The philosophy of midwives incorporates an

³²⁸ “Trends and Characteristics of Births Attended by Midwives,” *Statistical Bulletin*: Vol. 78, No. 1, Jan.-Mar., 1997), 10.

³²⁹ *Ibid.*, 9.

³³⁰ *Ibid.*, 9.

³³¹ *Ibid.*, 9.

emphasis on individualized attention and encouragement during pregnancy and delivery with the least amount of obstetric interference as possible.³³²

The United States birth certificate, between the years 1940 and 1988, had only one categorization for all midwife-attended deliveries. Before 1975, when statistics on midwife deliveries in hospitals initially became accessible, the assumption was that doctors performed all in-hospital births. Since 1989, however, the “attendant” section on the birth certificate has been extended, cataloging specialized nurse-midwives independently from “other” midwives. “CNMS are registered nurses who have completed graduate-level programs in midwifery, have been certified by the American College of Nurse-Midwives (ACNHN) and can legally practice in all 50 states and the District of Columbia with varying degrees of regulation.”³³³ “Other” midwives are a diverse section concerning instruction and preparation. They vary from “lay” midwives, some with little formal educational background, to graduate nurse-midwives, not yet ACNM certified. Nearly all states restrict lay midwives from practicing, but permit graduate nurse-midwives to attend patients while awaiting certification.³³⁴ In an ironic twist in Mississippi’s history, the 1950s and 60s witnessed “a major transfer of wealth and power from African American midwives to white male physicians,” according to Professors Elizabeth Payne and Martha Swain.³³⁵ While performing unpaid public health work for the state, these black midwives played a historically significant role in bringing

³³² Ibid., 10.

³³³ Ibid., 10.

³³⁴ Ibid., 10.

³³⁵ Elizabeth Anne Payne, Martha H. Swain, and Marjorie Julian Spruill, *Mississippi Women, Their Histories, Their Lives—Volume 2*. (Athens and London: University of Georgia Press, 2010), 151-153.

public health practices to rural (mostly) black Mississippians.³³⁶ The civic work of African American midwives in Mississippi was crucial to the achievement of state health agendas and had been made possible because of midwives' esteemed status in and intimate connection with the black community. Midwives had been concerned with the well being of their neighbors from the beginning of statehood, and state law in the 1920s gave them a chance to help with Mississippi's public health work. Since regulation placed midwives in frequent contact with public health nurses, midwives grew to be indispensable associates of nurses in state health strategy. From 1920 to 1950, midwives expanded their duties for community health care, notwithstanding state guidelines that placed restrictions on their work. At mid-century, the accomplishment of health reform in the state of Mississippi had largely depended on the duties of women at the bottom of the medical hierarchy—African American midwives.

³³⁶ Ibid., 151-153.

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